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ABSTRACT

Aimed at both policy makers and service providers, this report assesses services and policies regarding adolescent parents and pregnant adolescents and recommends a number of additions and changes. The first chapter examines the services already offered to pregnant adolescents and adolescent parents, including counseling, family planning, assistance with welfare or unemployment applications, and general education programs. Further services recommended concern the provision of food, shelter, and other personal necessities; physical, social, and emotional health services; prevention of child abuse and neglect; employment training and job placement; legal assistance; and staff training, outreach, and other program management activities. The second chapter discusses state policies and policy development for handling adolescent pregnancy and parenthood problems. The author recommends that policies address program coordination, staff selection and responsibilities, services development, and data collection. The final chapter reviews the problems of interagency collaboration in providing services. It offers guidelines for improving coordination as well as case illustrations of agency cooperation. Two appendices summarize the national survey from which this report was drawn and give examples of interagency coordination agreements. (Author/EW)

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SUGGESTED SERVICES AND POLICIES RELATED TO ADOLESCENT PARENTHOOD

A Report of the
Adolescent Parenthood Project

Sharon J. Alexander, Ph.D.

EA 014 192

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NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION
Adolescent Parenthood Project
Advisory Panel

Mr. Grant L. Anderson
State Board Member
Tacoma, Washington

Ms. Donnalou Burt
Counselor, Rocky Mountain
Planned Parenthood
Denver, Colorado

Betty Caldwell, Ph.D.
Donoghey Distinguished Professor
of Education
University of Arkansas at Little Rock
Little Rock, Arkansas

Ms. Sha Elvidge
Chief, School Health Section
Illinois Department of Health
Springfield, Illinois

Sara R. DePersio, M.D., M.P.H.
Director, Division of Maternal
and Child Health
Oklahoma Department of Health
Oklahoma City, Oklahoma

Effie Ellis, M.D., Co-Director
Quality of Life Center
Department of Human Services
Chicago, Illinois

Ms. Joanne Goldsmith
State Board Member
District Heights, Maryland

James F. Jekel, M.D., M.P.H.
Associate Professor of Public Health
Department of Epidemiology
and Public Health
Yale University Medical School
New Haven, Connecticut

Ms. Asta-Maria Kenney
Alan Guttmacher Institute
Washington, D.C.

Frederick R. Keyton, Ph.D.
Consultant in Pupil Services
Maryland Dept. of Education
Baltimore, Maryland

Lorraine Klerman, Dr. P.H.
Associate Professor of Public
Health
Brandeis University
Waltham, Massachusetts

Mr. W. Stanley Kruger
Director, Parent/Early Childhood
Special Programs Staff
U.S. Department of Education
Washington, D.C.

Ms. Theodora Ooms
Deputy Director
Family Impact Seminar
Washington, D.C.

Ms. Jeannie Rosoff, President
Alan Guttmacher Institute
Washington, D.C.

Ms. Linda Simkin Salsberg
Project Director
Welfare Research Inc.
Albany, New York

FOREWORD

This monograph seeks to make concrete the services and policies needed by pregnant adolescents/adolescent parents in an effort to facilitate policy and program efforts. The emphasis throughout is on the needs of pregnant adolescents/adolescent parents. However, because the prevention of pregnancy during adolescence is a critical concern, those who are at risk of pregnancy also are considered. Typically the services the at-risk population need--information, counseling and family planning--are much more limited although no less important than those needed by teenagers who are experiencing a pregnancy or parenthood.

This monograph addresses both policies and services, as the two are highly interdependent. While local services may be offered in the absence of state or local policies, policies do provide a firm foundation. Depending on the strength of a policy statement, it can require, recommend, allow, limit or prohibit services. The adoption of policies makes clear to policymakers and service providers alike what is to be done and what can be done.

An example of the impact of policy on the development of services was the legislative approval for using special education monies for pregnant minors in California. This policy resulted in the establishment of over 100 pregnant minor programs. Conversely, the reversal of the policy has jeopardized many of these programs. Another example is the eligibility requirement established under Medicaid for care related to pregnancy. Some states allow an adolescent to become eligible as soon as her pregnancy has been confirmed while others will pay for medical expenses only after she has delivered. The former policy encourages prenatal care by medical personnel while the latter imposes a financial hardship on them. Thus, policy can have a clear and tangible effect on the provision of services.

Similarly, the process of providing services can lead to the establishment of policies. Specific policy needs may become evident as services are being developed. For example, a school district found that some pregnant adolescents under age 16 were dropping out of school because pregnancy *per se* exempted them from the compulsory school attendance law. School district officials thought it was particularly important to change this policy because pregnant adolescents need schooling just as much if not more than other students. In another case, a program wanted to transport adolescent mothers and their babies, but the plan was halted when it was learned that state law prohibited infants on school buses. An exemption from the law for this and similar programs was requested.

While it is possible for services to exist in the absence of policies and policies in the absence of services, each can strengthen the other. Policymakers should recognize and assess the needs of pregnant adolescents/adolescent parents and adopt policies which support services to address these needs. Conversely, it behooves service providers to review existing policies and lobby for the establishment of a strong policy framework to support their efforts.

Finally, this monograph addresses the art of collaboration, specifically as it relates to agencies which provide services to pregnant adolescents/adolescent parents. Because agencies have different structures, functions, and perspectives, there are intrinsic barriers to interagency cooperation which must be overcome. The final chapter of the monograph provides guidance to personnel who seek to establish and foster interagency efforts.

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CHAPTER ONE: SERVICES

CHAPTER ONE SUMMARY

Services for pregnant adolescents/adolescent parents have evolved in the past hundred years from sheltered residential maternity homes where unmarried women stayed during their pregnancy and received assistance in placing their babies for adoption, to programs today which emphasize staying in school, good prenatal care, and helping young parents understand and raise their children. Estimates are that in the past 15 years the proportion of teenage mothers who decide to raise their children themselves has risen from 10 percent to 90 percent. This dramatic reversal has had a profound impact on our society which is only now being recognized. The types of services these women, their partners and families need has changed as well.

Recent studies have shown the negative consequences of early childbearing in terms of the health of the mother and child, a truncated education for the mother, limited employment and earning prospects, and developmental delays among the children. These findings, in conjunction with a fundamental reversal in the young woman's choice from placing the child for adoption to raising the child herself, have necessitated fundamental changes in the services provided to these young women, their partners, and their families.

A survey of existing programs for pregnant/parenting adolescents conducted by the Adolescent Parenthood Project shows that most programs provide counseling services and family planning information. The majority report that these adolescents have an opportunity to participate in an accredited educational program, and receive assistance in applying for additional support such as food supplements, welfare, and employment. A majority also provide family planning services, either on-site or through referral. In general programs provide a diversity of services to these adolescents and their families.

Programs and services for pregnant adolescents/adolescent parents may change in the future in several ways. Recognition at the state level of the needs of this population may increase. Services provided will change as the needs of these adolescents and their families evolve. Efforts to prevent adolescent pregnancy will probably increase. Programs may struggle even more to survive in the current fiscal climate and this adversity may lead to increasingly organized and sophisticated advocacy efforts.

Agencies and organizations interested in providing services to pregnant adolescents and adolescent parents may want to consider the following components for inclusion in a program:

- services which help provide basic personal necessities, e.g., food, clothing, shelter, financial assistance
- physical health services, e.g., prevention of illness, maintenance of health, diagnosis and treatment of medical and dental problems

- services related to social/emotional adjustment
- services designed to enhance family relationships or intervene to prevent abuse or neglect
- activities which enhance adolescents' positive self concepts
- general education
- employment training and job placement
- legal assistance
- program management activities, including outreach, program development and evaluation, public relations, staff training and transportation

Steps involved in development and implementation of services for pregnant and parenting adolescents include assessing needs, identifying resources, setting priorities and objectives, outlining the services/program, enlisting support, acquiring resources, implementing the program, and fostering community support. A diversity of services are needed by these adolescents to ameliorate possible negative consequences associated with early pregnancy and parenthood. While many organizations and programs have provided special services, much more assistance is needed.

BACKGROUND ON SERVICES

RATIONALE FOR SERVICES

Services addressing a wide range of needs are necessary if the potential short- and long-term negative effects of adolescent pregnancy and parenthood are to be mitigated. These effects include poor pregnancy outcome (Alan Guttmacher Institute, 1981), dropping out of school (Card, 1978), and welfare dependency (Moore, 1978). Health, education, social and other services must be available, and the evolution of these services for pregnant adolescents and adolescent parents during the past century reflects the changes that have occurred in society's values, morals and understanding about the effects of early parenthood.

Targeting services to pregnant adolescents and adolescent parents is fiscally responsible as well as humane. The cost of providing the needed diversity of services must be looked upon as a capital investment. If services are not provided at the onset of pregnancy and parenthood, a repeating cycle of low educational attainment, welfare dependency, alienation from the mainstream of society, increased family size, and developmental delays among the children will most certainly accrue heavy financial costs for our society.

THE ROLE OF ADOLESCENTS

Adolescent pregnancy and parenthood have become national issues only recently. At the turn of this century, it was an unwed pregnancy, not a teenage pregnancy, that was cause for great concern. At that time young women and men had lower educational expectations. A pregnancy during adolescence generally was accepted as long as the young woman was married. Children were considered an economic asset; at an early age they were expected to work on farms or in factories to contribute to the support of the family.

Since the turn of the century, the values and roles in our society have changed significantly. By the 1970s, completion of a high school education was a minimum standard, with further training recommended to obtain special skills. The roles of children and their contribution to the family have changed. In general, children in today's society are a financial liability rather than an asset. Because they are expected to remain in school longer than in earlier decades, most of them are not expected to hold a job or to contribute earnings to the family. In general, children are expected to be students until at least age 16, and often for many years beyond.

Attitudes toward children and the roles of parents have changed as well. Whereas in the past children were considered property and therefore had no rights independent of parents, today they are seen as individuals with many rights. Parents are expected to provide a happy, healthy, and

wholesome environment for their children. While in the past parents often expected children to follow in their footsteps and to live a similar lifestyle, many parents today want their children to have the things they never had and to surpass them in accomplishment. In many families, children are the focal point. In general, family roles have shifted from having children contribute to the well-being of the parents to having parents direct their efforts to the well-being of their children. This change reflects, in part, a more financially secure populace and a different attitude toward child development.

The onset of a pregnancy during adolescence is generally stressful to the teenagers and their families. To help them cope with this event, a variety of services has been provided. A brief history of the evolution of services in the past hundred years follows.

HISTORY OF SERVICE PROVISION

The Florence Crittenton homes were established in 1883, beginning in New York City and spreading to many cities across the country. These were boarding homes where a pregnant woman, usually unmarried, could live until the birth of her child. Shelter, food, clothing, counseling, and a supportive environment were provided to help her through this difficult time. Frequently the woman placed the child for adoption. In 1887, the Salvation Army opened a similar home for unwed mothers in Brooklyn. Other private social organizations such as local Catholic Charities and child welfare agencies also developed programs for pregnant young women and provided many of the same services. Such homes were the major service providers for several decades.

While social service agencies were responding to the needs of these women in some communities, the educational establishment was not. Pregnant students either dropped out or were required to leave. This practice reflected a fear that pregnant students would "corrupt" others and set a poor example, as well as the philosophy that women who were mothers should stay home with their children. However, by the late 1960s and early 1970s, many special educational programs were established to develop and coordinate needed services. Many of these programs were situated in alternative school settings where pregnant adolescents were taught the standard subjects as well as courses specifically related to pregnancy and child development.

One of the first comprehensive school-based programs for pregnant teenagers was the Webster School located in Washington, D.C. Established in 1962, it provided health, education and social services. Many other large school districts created special alternative schools for pregnant adolescents, based on the Webster model. In 1972 the Webster School was discontinued because a policy change encouraged pregnant adolescents to remain in their regular school. This change also reflected a concern about the cost of the special program.

The enactment of two pieces of federal educational legislation in the 1970s may have resulted in a decrease in the number of school-based programs. Title IX of the Education Amendments of 1972 prohibits discrimination on the basis of sex, thereby ensuring that young women who are pregnant or parents cannot be excluded from school on that basis. Further, in Section 86.40, it requires that any separate instructional program for pregnant adolescents be optional and that it be comparable to the program offered to non-pregnant students. To assure compliance with this law, some school districts have discontinued separate programs altogether, an unplanned side effect of a law trying to protect this population. In addition, the Education for All Handicapped Children Act of 1975 (P.L. 94-142) requires that all handicapped students be "mainstreamed" into the regular classroom to the extent possible. This law emphasizes the importance of integrating handicapped students into the regular school program. As such, it has set a standard which can be applied to pregnant adolescents/adolescent parents. The impact of these laws on adolescent parenthood programs across the country has varied; in many areas they have discouraged special programs.

Costs also may have influenced program growth and development. Because the scope of services provided through such special programs is broader than the standard program, it is reasonable to assume that the financial cost is greater. This increased expense may have contributed to the demise of programs or, in some cases, their failure to be developed. However, if a program is well coordinated and administered, costs can be reduced significantly, and many districts have developed and continue to provide special programs. Overall, education agencies are much more responsive to this population than 20 years ago because they recognize the right of pregnant adolescents/adolescent parents to continue their schooling.

Health services during the early 1900s usually were provided to pregnant adolescents in private physicians' offices or public clinics. Teenagers were treated just like other pregnant women with little recognition that they needed special counseling about prenatal health care, diet, and fetal development. Decades later, with the advent of public health programs targeted to certain populations, the needs of adolescents were recognized to some extent. Title V (Maternal and Child Health) of the Social Security Act of 1935 and Title X (Family Planning) of the Public Health Service Act of 1970 both provide fertility-related health services to adolescents at little or no cost.

Moreover, legislation recently was passed to target pregnancy-related group care to adolescents. The Health Services and Centers Amendments of 1978, through Titles VI, VII, and VIII, created the Office of Adolescent Pregnancy Programs which funds local coordination of community-based services. The legislation also speaks to the need for preventive health services for teenagers. These legislative endeavors demonstrate that pregnant adolescents and adolescent parents have, to some extent, been recognized as a population in need of special health services.

Advocacy at state and local levels has contributed to this recognition and encouraged the development of programs, services, and state level efforts including legislation and appropriations. Florida, Michigan, New York and Washington all made this population a priority during the 1970s. Perhaps California, which begin its efforts in the late 1960s, led the way. A consultant for the California Department of Education suggested that pregnant minors be covered for special services by monies from special education. In 1968, legislation was passed to allow this classification. Over 100 programs developed and a network of service providers grew in size and strength. Advocates who are trying to assure that these programs continue are faced with the grim realities of California's financial crisis. Currently, the trend seems to be to eliminate the programs. To counter this decline, advocates are linking the cost of providing services now to the cost of long-term dependency if these young women and their families stay on welfare.

The need for effective advocacy efforts continues. However, in the past few years, health, education and social service-based programs for adolescents have suffered from the inflationary spiral as well as competition from other special populations for funding and services. This trend may escalate, given the new fiscal stringency at the federal level.

Overall, there has been a striking change in the kinds of programs and services offered to pregnant adolescents in the past 50 years. According to the most recent survey of programs (NACSAP Directory, 1976) more than half of the programs are education-based, followed by health and social service programs. Less than 10% of the programs are residential, in contrast to programs in the early 1900s. As residential programs have decreased, emphasis has been placed on coordinating a diversity of services through a network of providers to meet the unique needs of each adolescent. What services do programs provide now? How will programs change in the near future? These questions are addressed in the next two sections.

SERVICES PROVIDED TO CLIENT GROUPS

The National Association of State Boards of Education collected information from adolescent parenthood programs nominated as exemplary by state health, education and social service agency personnel and from other programs as well. Appendix A contains a detailed write-up of the research methodology as well as data on the administration, funding, staffing and clients served by these programs. The data gathered about services are discussed here as an illustration of what some adolescent parenthood programs provide.

Twelve items were included on the questionnaire relating to the health, education, and social services offered by the programs. Where there were no substantial differences between exemplary and non-exemplary programs in the provision of these services, the data have been aggregated.

HEALTH SERVICES

Almost all programs (91%) reported that they offered family planning information. The majority of programs (51%) reported that they used three different media to present this information: discussion/lecture materials, audio-visual aids and printed materials. The other programs reported using one or two of these media with discussion/lecture being the most common. Information on birth control methods--condom, diaphragm, foam, IUD, natural family planning and the pill--was also offered by most of the programs.

Family planning services were provided most frequently through referral (48%) followed by services on-site (31%). Approximately 20 percent of the programs did not provide family planning services, either by referral or on-site. The majority of programs offered health screening services for clients. While 3.6 percent of the programs focused exclusively upon the pregnant adolescent from time of program entry to delivery, 96.3 percent of the programs extended their services beyond childbirth.

Table 1 details the percentage of programs which provided services related to pregnancy and child care. Perhaps most striking about this breakdown is the widespread similarity between the exemplary and non-exemplary programs in how they provide these services--on site, by referral, or not at all. Only in four categories--pregnancy testing, adoption, well-baby check-ups, and child day care--is there a substantial difference in how each type of program provided these services. In general, the exemplary programs were more likely to provide health services on-site while the non-exemplary programs were more likely to provide adoption and infant/child day care services on-site.

COUNSELING SERVICES

Almost all respondents (95.1%) reported that their program provided clients with counseling services in either individual (91%) and/or group (68%) settings. Table 2 summarizes the types of counseling services which were offered. It is not possible to determine whether these services were provided by professionals specifically trained in these fields (e.g., psychologists, social workers and counselors) or whether they were provided by others.

Table 1
Services Related to Pregnancy and Child Care

Services	Provided On Site		Provided By Referral		Not Provided	
	E. N=81	N-E. N=124	E. N=81	N-E. N=124	E. N=81	N-E. N=124
Pregnancy testing	28%	18%	53%	52%	19%	30%
Abortion	3	5	59	58	38	37
Adoption	5	15	79	66	16	20
Prenatal care	40	40	48	47	12	13
Perinatal care	33	34	53	50	14	16
Postnatal care	40	38	47	47	13	16
Well baby check-ups	29	19	53	54	18	18
Treatment for sick children	18	11	60	57	22	32
Developmental assessment	37	30	37	36	26	35
Infant day care (0-6 mos.)	35	42	31	24	34	34
Child day care (7 mos. +)	30	39	34	27	37	35

Table 2
Counseling Services Provided to
Pregnant Adolescents/Adolescent Parents

Counseling Service	Always Provided N=205*	Provided Upon Request N=205*
Family Planning	72.2%	18.1%
Adoption	53.4	34.6
Abortion	36.8	36.6
Raising the Child	74.1	14.6
Foster Care	42.0	37.6
Getting Married	57.6	29.8
Living with Parents	57.6	27.3
Setting Up a New Household	55.1	26.3
Financial Planning	55.6	29.8
Employment	48.9	30.7
Personal Development	68.3	12.7
Interpersonal Relationships	61.5	11.7

* Due to small differences between exemplary and non-exemplary programs the data has been aggregated.

EDUCATIONAL SERVICES

Educational services also were offered by most programs. The majority of respondents (54%) reported that their pregnant female clients had an opportunity to participate in an accredited educational program. Approximately 66 percent of all respondents indicated that pregnant teenagers received course-work toward meeting minimum graduation requirements in a separate setting. Table 3 details information on the general and specific subjects offered to pregnant adolescents/adolescent parents in the regular school and special settings. Physical education, vocational skills training and work experience are the areas addressed least often by the respondents.

Table 3
Course Content in Regular and Special School Settings*

	Regular School		Special Setting		Total
Course Content	E	N-E	E	N-E	
Courses which fulfill minimum graduation requirements	22	31	34	78	165
Physical education	15	25	24	48	112
Family life/parenthood education	16	22	34	79	151
Sex education	16	23	33	77	149
Child development	12	23	32	84	151
Nutrition education	16	23	30	81	150
Career exploration	15	27	29	68	139
Vocational skills training	16	26	25	51	118
Work experience	9	22	26	46	103
Life skills	13	21	31	67	132
Using community resources	14	20	31	64	129

* Actual number of programs responding; some programs reported providing services in both settings.

SOCIAL SERVICES

A variety of social services are provided by the majority of programs. Table 4 shows that a slightly higher percentage of exemplary programs offered this kind of assistance in all categories. Only 16 (20%) exemplary and 18 (15%) non-exemplary programs maintained a telephone hotline through which pregnant adolescents/adolescent parents could receive advice and information.

Table 4
Application Assistance

Service/Program	Exemplary N=81	Non-Exemplary N=124
WIC	76.5%	74.2%
AFDC	75.3	73.4
Medicaid	55.6	62.1
Foster Care	64.2	54.0
Housing	56.8	53.2
Legal Assistance	66.7	62.9
CETA	62.9	58.1
Employment other than CETA	55.5	51.6

Both types of programs were able to direct a range of services to pregnant adolescents and adolescent parents and to their families.

FUTURE TRENDS

Given the scope of services provided by these programs, the Reagan administration's approach to human services and the evolution of programs to date, what changes can be expected in services in the future? Several trends suggest how service provision for pregnant adolescents and adolescent parents may change in the future. These include:

1) increased recognition of the importance of state level efforts;

2) greater evaluation of the impact of services;

3) targeting needed services to adolescents and their families;

4) increased emphasis on prevention efforts;

5) greater financial constraints; and

6) development of organized advocacy efforts.

STATE LEVEL EFFORTS

In the mid-70s a number of state agencies targeted needed services to this population and, in the future, federal monies may enable states to further consider pregnant adolescents/adolescent parents a priority. Just as the availability of funds from one small categorical program (Office of Adolescent Pregnancy Programs) has been a catalyst to get states and communities to collaborate on this issue, so the provision of other monies will encourage a focus on these adolescents. As the federal government turns over more responsibility to the states, they will have to look increasingly to their own coffers for the needed funding.

While many state agencies have worked in conjunction with other agencies, successful collaborative efforts have been sporadic. Within the past eight years a number of state committees and task forces, separate from any particular agency and sometimes under the auspices of the governor, have been directed to review current and potential efforts to address the needs of adolescent parents. These state groups have also borne the responsibility for developing statewide approaches to preventive and treatment services. If these committees are successful, other states may adopt this approach to providing an array of services based on expertise, commitment and availability of funds.

EVALUATION OF THE IMPACT OF SERVICES

While there is no national standard for programs that provide services to pregnant adolescents and adolescent parents, the legislation which created the Office of Adolescent Pregnancy Programs in 1978 specified a set of core services which had to be provided by the grantee. These were: pregnancy testing, maternity counseling, and referral services; family

planning services; primary and preventive health services; nutrition information and counseling; referral to appropriate pediatric care; educational services in sexuality and family life; referral to appropriate educational and vocational services; adoption counseling and referral services; and referral to other appropriate services. In addition there is a set of supplemental services which may be provided: child care; consumer education and homemaking; counseling for extended family members; transportation; and other appropriate services. These lists of services provide a standard of comparison for existing programs. Other lists, like the one contained in the section on suggested services, may also provide some guidance.

In the past, evaluation of program activities has been the exception rather than a standard practice. While some programs have an assessment procedure, very few have published their results (Osofsky et al., 1968; Klerman and Jekel, 1973; Edwards et al., 1980). Of the respondents to the NASBE survey, only 23% ever published their results in any form. However, because there is a growing demand to document the impact of programs as justification for their existence, this type of evaluation probably will increase in the future. This is so despite the lack of standards for assessing programs and the quality of services, a void which makes evaluation more difficult and aggregating results across programs virtually impossible. Perhaps some assistance will be provided through the research being done under the auspices of the Office of Adolescent Pregnancy Programs, which includes an assessment of approximately 1,000 existing programs for pregnant adolescents. To the extent that standard measurement criteria can be established, program evaluation will be facilitated.

TARGETED SERVICES

Health-based programs probably will continue to use federal funds which can be targeted toward this population, such as Titles V and X. These programs are adapting their services to better meet the special needs of adolescents. Education-based programs are likely to keep adolescents who are pregnant or parents in a regular school setting. They may develop strong outreach programs to encourage these adolescents to return to school.

Many residential homes for pregnant women have changed the focus of the services provided over the years. To some extent this shift has resulted in a less pronounced emphasis on single mothers. Some programs now provide residential care for mothers and infants, while others have expanded their target population to include troubled youth. Many programs have added non-residential services such as counseling, and helping adolescents access community resources. Such trends are likely to continue as social service programs adapt to meet the needs of youth in their communities.

PREVENTION EFFORTS

Programs are beginning to provide preventive and treatment services to young men and these efforts may be expanded to involve additional family members, something which has generally been done on a request basis only. Family involvement may increase as service providers become aware of the implications of an adolescent pregnancy for all family members.

The emphasis on prevention probably will expand as more is learned about successful approaches. Some of the methods used in programs to date have highlighted the importance of learning to act responsibly and postponing sexual activity. Other approaches stress the need to learn about a variety of contraceptive methods and their application.

Prevention has received greater emphasis in recent years. The federal Title X Program (Family Planning) has earmarked substantial funds for outreach and family planning services to adolescents. Some schools also offer sex education as part of their curriculum, including information on family planning services. As adolescents receive clear, correct and comprehensive information on human sexuality, they will be better prepared to make informed decisions based on knowledge rather than ignorance and myths.

Some conservative groups are campaigning to prohibit sex education and the provision of contraceptives to minors. It is uncertain at this point how successful they will be at the local, state and federal levels in getting policies and programs which reflect their views. If the philosophy of the general public changes to be more restrictive, the provision of services to adolescents may change as well.

While many adolescents no longer ascribe to the belief that sex is acceptable only after marriage or adulthood, they have not yet replaced it with a belief that using contraceptives to prevent unwanted pregnancy is essential. Prevention efforts will continue and will encourage adolescents to act responsibly by postponing sexual activity until they are older and/or by using effective contraceptive methods consistently.

FINANCIAL CONSTRAINTS

The fiscal outlook for human services programs is bleak at the present time. The passage of tax ceilings in many states, often below existing levels, combined with the goal of balancing the federal budget and increasing spending for defense, means that programs such as those serving pregnant adolescents/adolescent parents are a low priority. Federal and state monies which have been used for many years to provide services are being reviewed very carefully, with the goal of reducing spending wherever possible.

Though the current financial climate generally is discouraging, it provides a challenge as well: using cost-benefit arguments to justify these programs. Such analysis requires careful documentation and evaluation, elements which many programs have lacked. This information, utilized by effective advocates, will increase understanding about the financial costs to society of not providing services, thus encouraging continued support for these programs.

Perhaps foundations and businesses will be more receptive to funding services for this population. If, in fact, businesses prosper greatly in the next few years, they may wish to expand their civic contributions. Programs for pregnant adolescents/adolescent parents could be the beneficiaries of such donations. It behooves program administrators to look beyond state and federal monies and begin (if they haven't already) to

establish relationships with potential donors. Given the current fiscal climate, acquiring funds will continue to be one of the major stumbling blocks to providing services to this population.

In addition to financial cutbacks, the proposal to consolidate many federal programs--including Titles V, VI and X--into block grants has tremendous implications for adolescent services. If such block grants become a reality in the next few years, priorities probably will be established at the state level and thus could vary significantly among states. This change will necessarily lead to a redirection of lobbying efforts from the federal to the state levels. In states that already have a well organized network, youth advocates will be better prepared for this change; however, most states do not have such organizations. Concerned individuals need to organize as quickly as possible at the state and local levels to assure that pregnant adolescents/adolescent parents receive adequate consideration when priorities are determined.

ADVOCACY EFFORTS

A strong advocacy network would make a significant contribution to continued and perhaps increased local, state and federal efforts. Without an organized group of supporters continually emphasizing the importance of services to these adolescents, efforts will fluctuate, decrease and may stop. With the demise in 1978 of the National Alliance Concerned with School-Age Parents, a national membership organization for persons working with pregnant adolescents/adolescent parents, the existing network of service providers was left without leadership or structure. It is unclear at this time whether the National Organization of Adolescent Pregnancy and Parenting and/or the Office of Adolescent Pregnancy Programs or other on-going efforts will be able to organize an effective national advocacy effort. Several state-level advocacy efforts continue to play a role in individual states. If efforts such as these can be nurtured and expanded, voice can be given to the needs of these special youth.

Such advocacy efforts are critical at a time when the federal government is emphasizing national defense at the expense of human services. Advocates may have to be particularly well organized and informed in the next few years just to maintain existing programs. While the short-term prospects may be bleak given existing financial constraints, they will be even more dismal without the support of an active advocate network.

Charting the course that programs and agencies will use in the future is only educated guesswork. The potential for targeted, widespread and more effective efforts is in place. Whether this potential can be organized and promoted will depend to a great extent on the commitment and skills that can be brought to bear at the local, state and federal levels by individuals who are concerned about youth.

SUGGESTED SERVICES

To guide program developers, a comprehensive list of services for pregnant adolescents, adolescent parents and their families is detailed in this section. This list can serve a variety of purposes. It can be a basis for the identification of services in the community, one of the key components of a needs assessment (discussed later in "Implementing the Suggested Services"). Second, it can provide direction to program administrators as they seek to expand their programs. Third, it can be an evaluation tool used by administrators to measure the comprehensiveness of programs. Fourth, the definitions provide a common basis for discussion of each service which can be an invaluable aid when people from different agencies and locales collaborate. Thus, the list and definitions provide guidance on what a comprehensive program for pregnant adolescents and adolescent parents entails.

It should not be inferred that a single program site should provide each and every one of these services if it is to be comprehensive. However, services should be available to adolescents in the community and a program should help them access all the services they need. Each adolescent will not require every one of these services; therefore, flexibility is important in tailoring the program to meet individual needs.

FRAMEWORKS FOR SERVICES

A number of frameworks have been devised for categorizing services to youth, particularly pregnant adolescents and adolescent parents. One organizes the provision of services around pivotal decision-making points, such as becoming sexually active, using contraceptives, or exploring pregnancy options (Klerman, 1981). At each point, adolescents should receive counseling and a variety of health, education and other services according to their needs. This framework is oriented to the individual and can be particularly useful in helping providers target their services most efficiently. It is appropriate for the direct service provider, especially one who has an interdisciplinary array of services to offer. It is less appropriate for state agency personnel in structuring their policies and approaches.

Another framework divides the services into health, education, social services and miscellaneous categories, based on the major agencies that directly serve this population. This approach makes clear which agency is primarily responsible for a particular service. This paradigm has two liabilities: it may narrow the view of service providers and agency personnel to only those services listed under their category, e.g., health, education or social services; and it leads to the creation of an extensive "miscellaneous" category, further fragmenting the provision of services. While some services are more directly tied to the expertise of a particular agency, it is important to consider using a collaborative approach designed to meet the needs of the adolescent.

Another framework has been formulated by the Comprehensive Adolescent Services Project conducted by Welfare Research Incorporated and the New York State Council on Children and Families. In developing a survey to assess comprehensive adolescent services, they generated a list of eight generic categories:

1) basic personal necessities;

2) physical health;

3) social/emotional adjustment;

4) family support;

5) adolescent development;

6) education;

7) training/employment; and

8) legal assistance.

This approach is particularly helpful because it cuts across the standard divisions of health, education, social and other services and thus avoids making any particular agency responsible for the provision of these services. In addition, it emphasizes the kinds of needs a client may have, thus capturing both the client-centered focus of the decision-making framework and the specificity needed by agencies and service providers. For these reasons it was selected as the framework for the program components suggested here. An additional category entitled "Program Management" has been included.

Agencies and organizations interested in providing services to pregnant adolescents and adolescent parents may want to address the needs evident in all or several of these categories. Ideally, a comprehensive program would provide and/or access all these services.

The services are listed in two formats:

1) nine categories, each briefly defined, followed by the services appropriate within that category; and

2) a definition of each service (listed alphabetically).

SUGGESTED SERVICES

Basic Personal Necessities: Food, clothing, shelter and financial assistance: those services which help to provide the basic necessities of life.

- AFDC Application Assistance
- Housing
- Residential Care
- Snack/Meal
- WIC

Physical Health: Prevention of illness, maintenance of health, diagnosis and treatment of medical and dental problems.

- Abortion
- Dental Screening and Care
- Developmental Assessment of Child
- Family Planning
- Health/Nutrition Education
- Perinatal Care
- Postnatal Care
- Pregnancy Testing
- Prenatal Care
- Prepared Childbirth Training
- Preventive Medicine
- STD Screening and Treatment
- Well Baby Check-Ups

Social/Emotional Adjustment: Services related to the client's adjustment to his/her social environment when there is a problem (whether defined by the client, authority figure or society).

- Counseling for Families
- Counseling for Fathers
- Counseling for Pregnant Adolescents
- Counseling on Pregnancy Options
- Foster Care
- Home Visiting
- Homemaker Service/Parent Aid
- Hotline

Family Support: Services designed to enhance adolescents' relationships with their families or intervene to prevent abuse or neglect.

- Adoption
- Child Day Care
- Infant Day Care
- Monitoring for Abuse and/or Neglect

Adolescent Development: Services and/or activities which enhance adolescents' positive self concepts, and enable them to: develop positive relationships with peers; seek or provide community service; have opportunities to succeed or fail at new activities; or just relax.

- Accessing Community Resources
- Advocacy
- Interpersonal Skills Training
- Peer Counselor Training
- Program Planning Involvement
- Recreation

Education: Services related to the general education of normal and special populations.

- Child Development/Parenthood Education
- Consumer Education
- Educational Counseling
- Family Life/Sex Education
- Home Economics/Home Management
- Regular Educational Program
- Student Financial Assistance

Training/Employment: Services associated with readiness to seek and accept employment and job placement.

- Career Exploration
- Job Counseling
- Job Referral/Placement
- Job Skills Training
- Vocational Training
- Work Experience

Legal Assistance: Services related to rights and responsibilities as established by law.

- Legal Aid

Program Management: Activities of a program to assess, improve or reach out to provide its services.

- Case Advocacy
- Outreach Services
- Program/Curriculum Development
- Program Evaluation
- Public Relations
- Staff Training
- Transportation

DEFINITION OF SERVICES

ABORTION

- Medical procedure to terminate a pregnancy.

ACCESSING COMMUNITY RESOURCES

- Activities designed to help the adolescent become more familiar with her/his community, its resources and how to access them.

ADOPTION

- Legal procedure leading to the relinquishment of a child by birth parents for placement with new parents.

ADVOCACY

- Providing training and opportunity for pregnant adolescents and adolescent parents to speak out on behalf of their needs.

AFDC APPLICATION ASSISTANCE

- Aid in determining eligibility for financial assistance from Aid to Families with Dependent Children and help in applying for such assistance.

CAREER EXPLORATION

- The study of various careers, specific jobs, and their education and training requirements to help an individual match her/his interests and abilities with possible career choice areas.

CASE ADVOCACY

- Assistance provided to help an adolescent negotiate the "system" to receive the service(s) she/he needs.

CHILD DAY CARE

- Care of child from 6 months to school age while parent is in school or working.

CHILD DEVELOPMENT/PARENTHOOD EDUCATION

- Courses concerning family living, parenting skills and the growth and development of children.

CONSUMER EDUCATION

- Teaching units/courses to educate people on how to be effective consumers of goods and services.

COUNSELING FOR FAMILIES

- Exploring with families who have a member involved in an adolescent pregnancy their concerns, needs and feelings.

COUNSELING FOR PREGNANT ADOLESCENTS

- Exploring with pregnant adolescents their personal concerns including, but not limited to, those associated with the pregnancy, their families and friends, health, education, job training and placement, and child care.

COUNSELING ON PREGNANCY OPTIONS

- Counseling regarding continuing or terminating pregnancy including the options of abortion; adoption; or raising the child at home with family, alone, or with a partner.

DENTAL SCREENING AND CARE

- Examination and follow-up treatment by dentist.

DEVELOPMENTAL ASSESSMENT OF CHILD

- Behavioral assessment to determine how infant/child is progressing compared to others the same age.

EDUCATIONAL COUNSELING

- Advising a student on the selection of courses based on her/his abilities, preferences, needs and career interests. Information about training institutions, financial assistance, and entrance requirements should be included as appropriate.

FAMILY LIFE/SEX EDUCATION

- Courses structured to teach adolescents about interpersonal relationships, communication, decision-making, human sexuality, values, roles of family members, marital options and parenthood.

FAMILY PLANNING

- Information, counseling and services regarding fertility issues based on economic and social considerations such as family size, child spacing and timing; and based on biological considerations such as genetic counseling and birth control methods.

FOSTER CARE

- Placement of a minor with a family to which she/he is not related to receive parental care and nurturance.

HOME MANAGEMENT/HOME ECONOMICS

- Courses designed to prepare adolescents for homemaking, including budget planning, purchasing goods and services, food preparation, home maintenance and upkeep.

HEALTH/NUTRITION EDUCATION

- Education regarding proper health and nutritional habits, preparation of food and the importance of both to healthy development for mother and child.

HOME VISITING

- Visits by trained personnel to the home of the pregnant adolescent/ adolescent parent to assess the adolescent and her/his family in order to provide and/or recommend assistance needed for child care and development, obtaining food, clothing, welfare, etc.

HOMEMAKER SERVICE/PARENT AID

- Help in homemaking duties to temporarily assist and/or relieve the parent.

HOTLINE

- Telephone service staffed by trained personnel to answer an adolescent's questions pertaining to personal, health, child care and social concerns.

HOUSING

- Identification and/or provision of shelter such as boarding homes, foster care and group homes or apartments for pregnant adolescents/ adolescent parents who cannot live at home; such alternative settings may provide adult supervision.

INFANT DAY CARE

- Care of child up to age 6 months during the day while parent is in school or working.

INTERPERSONAL SKILLS TRAINING

- Instruction and exercises to help people learn to communicate effectively and get along with others.

JOB COUNSELING

- Exploring with an adolescent her/his current and/or future job prospects as well as concerns related to a particular job.

JOB REFERRAL/PLACEMENT

- Referral of a client to and possible placement with an employer who has a job opening for which the client qualifies.

LEGAL AID

- Provision of information, counseling and services for pregnant adolescents and adolescent parents regarding their legal rights, responsibilities, and status.

MONITORING FOR ABUSE AND/OR NEGLECT

- Screening the infant/child and the living situation for detection of possible abuse and neglect; counseling and/or referral of any cases so identified.

OUTREACH SERVICES

- Information about and provision of services to adolescents at places they frequent.

PEER COUNSELOR TRAINING

- Information and practice, to prepare adolescents to become information, referral, and counseling resources for other adolescents.

PERINATAL CARE

- Medical care and attention during birth and the immediate period of time surrounding it for mother and infant.

POSTNATAL CARE

- Medical monitoring of the health of the new mother and provision of medical care as indicated.

PREGNANCY TESTING

- Medical procedure to determine pregnancy.

PRENATAL CARE

- Medical supervision and care during term of pregnancy.

PREPARED CHILDBIRTH TRAINING

- Training the pregnant woman and her coach in the method of delivery which uses little or no drugs or anesthesia.

PREVENTIVE MEDICINE

- Medical care designed to anticipate and prevent the development of health problems or to detect and treat them in their early stages.

PROGRAM/CURRICULUM DEVELOPMENT

- Activities designed to improve/expand the program, through its materials and/or its services.

PROGRAM EVALUATION

- Assessment by clients, staff and/or others to determine the effectiveness of the program.

PROGRAM PLANNING

- Involvement of pregnant adolescents and/or adolescent parents in the development and provision of services through the program.

PUBLIC RELATIONS

- Communication, through the media and personal contacts, about the program and its purposes, with the goal of educating others about pregnant adolescents/adolescent parents, their needs and the program's services.

RECREATION

- Activities provided for amusement, entertainment, and/or relaxation.

REGULAR EDUCATIONAL PROGRAM

- Courses available to all students which provide credit toward graduation, and other services provided by school personnel such as counselors, nurses, and social workers.

RESIDENTIAL CARE

- Lodging for adolescents during pregnancy; in addition to housing and food, health, education and/or social services also may be provided.

SNACK/MEAL

- Provision of nutritious food to pregnant adolescents and/or young children enrolled in a program.

STAFF TRAINING

- Inservice or special training of staff to teach skills to aid in handling problems faced by adolescents who are pregnant or parents and their families.

STUDENT FINANCIAL ASSISTANCE

- Aid to help a student meet the costs of her/his post-secondary educational training.

STD SCREENING AND TREATMENT

- Testing for sexually transmitted diseases such as gonorrhea, syphillis and herpes simplex II, and providing appropriate treatment and counseling.

TRANSPORTATION

- Provision of public or private transport to pregnant adolescents/adolescent parents in need of services not provided in a single-site program; could include transportation itself or financial assistance to pay for the transportation.

TREATMENT FOR SICK CHILD

- Medical care for infants and children when they are ill.

WELL BABY CHECK-UPS

- Routine medical examinations of infants/children.

WIC

- Supplemental food program for women, infants and children; federal funds provided through the U.S. Department of Agriculture.

WORK EXPERIENCE

- Learning acquired on the job.

IMPLEMENTING SERVICES

This section discusses the implementation process and provides guidance on developing or expanding services for pregnant adolescents/ adolescent parents. Implementation includes the following steps:

1) assessing needs;

2) identifying resources;

3) setting priorities and objectives;

4) outlining the services/program;

5) enlisting support;

6) acquiring resources;

7) fostering community support; and

8) implementing the program.

These steps provide a general outline which should be tailored to meet circumstances in each community.

ASSESSING NEEDS

Before designing a program, it is essential to find out what the needs in the community are. To evaluate these needs, it is important to study two factors: data on adolescents in the community and services that are already provided. A number of questions must be answered in each category.

- DATA COLLECTION: What is known about pregnant adolescents and adolescent parents in the area to be served? How many births were there to adolescents in the last calendar year? What percentage of all births for that period were to adolescents? What is the nature and degree of problems related to pregnancy among adolescents? How many adolescents in school are pregnant or parents? How does that compare to the number of births to adolescents in the area? Answers to these questions will be more helpful if adolescents are defined on an age-specific basis; for example, how many births to adolescents are to young women who are fifteen years of age or younger?

- SERVICES: What services are already available that could be targeted to adolescents? Can they be provided at an existing center or community facility? Are adolescents able and willing to use these site(s)? Are the services free to adolescents? If not, can adolescents afford them? Are the staff responsible for providing the services trained and experienced in working with adolescents? What services are not available?

The answers to these questions should guide the essential needs assessment stage. This fact-finding exercise might reveal that services are already being provided. Similarly, it might uncover some needs which are not currently being met which should be addressed.

IDENTIFYING RESOURCES

Closely linked to assessing needs is identifying resources including people, money, facilities, and supplies. Each of these resources needs to be thoroughly explored.

- PEOPLE: Who is already concerned and/or doing something to provide services or other support to this population or a similar group? What do they know about current and potential resources available? Ask them to suggest people to contact, things to do as well as pitfalls to avoid. Involve them in the effort and keep them informed. Building a relationship with others with similar interests will be very helpful.

- MONEY: What agencies, organizations or individuals have money that could be accessed to provide services to this population? What criteria must be met to compete for this money? Are there spending limits? Has anyone else been successful in utilizing these resources for this or similar populations? If yes, would another request be viewed as a helpful addition or a duplication? How would another effort fill a community need? In what ways is it unique? Is this need a recognized priority?

- FACILITIES: Who can provide space for the effort? Are the facilities suitable for the purposes which have been established? What obligations are attendant upon use of the facilities? Are the facilities convenient and appealing to adolescents?

- SUPPLIES: Who can donate items which could be utilized by the adolescents and/or the program, including clothing, food, medical supplies, infant clothing, sewing machines, typewriters, etc.? How will the materials be collected and distributed?

After completing a needs assessment and a survey of existing resources, it will be possible to determine with more precision the number of adolescents who need services and the services currently provided, as well as what money, facilities, and other forms of support might be channeled through a program.

SETTING PRIORITIES

Assuming that additional services are needed, the next step is to set priorities. What can the program reasonably expect to provide? What services are feasible in the short-run? What needs should be postponed until later? What other steps should be taken to obtain the necessary support and funding for the proposed efforts?

These and many other questions should be answered to assess how to begin the program. Try to mesh what can be done now with what is needed most. In developing a list of priorities, it may be helpful to enlist the participation of other people in the community who are knowledgeable about existing services and current needs. If a board of directors has been established for the program, the advice of its members should be sought.

Setting priorities should be done carefully because it will significantly influence the program and its evolution. Establish long-range priorities as well, with projected timelines, to indicate future goals for the program. It may be necessary to begin with a program limited in scope, but it will be better than no program at all. The top priorities should be the basis for the proposed program. Once it is established, the staff can work toward a more comprehensive program in the future.

OUTLINING THE SERVICES/PROGRAM

At this point the program should be outlined. The proposed effort should fill a critical gap--not duplicate existing efforts. It is important to remain flexible, keeping in mind a clear idea of what should and can be done. All of the possible approaches should be considered. For example, in planning an educational program, what setting is best to serve the clients: a special program in an alternative school? in the regular school? in another setting? The same types of questions should be asked when considering the other services to be provided. The outline of services should guide discussions with potential supporters and contributors. Their expertise should be used in finalizing the proposed program.

ENLISTING SUPPORT

Enlisting support is the next important step to be taken. If a city-wide, county-wide or state-wide effort is planned, it is important to involve the top officials--mayor, county commissioner, legislators, governor--at this stage. They should be given information about the level of need and possible solutions toward meeting that need. It is helpful to get their support early in the program development process. Outline how the proposed plan would address the existing needs to the following people as well:

- potential supporters, including those who assisted in the needs assessment and resource identification stages;
- key administrators who would need to give approval for this effort as well as their staffs; and
- pregnant adolescents and adolescent parents.

When enlisting support, one of the key items to be discussed is the designation of pregnant adolescents/adolescent parents as a priority. Recognition of them in this way can result in a redirection of funds demonstrating that there is government/agency concern about and commitment to addressing their needs. Priority status will, in turn, raise awareness of the services needed and this visibility can aid future efforts.

ACQUIRING RESOURCES

After existing resources have been identified, the program outlined, and supporters enlisted, in-kind contributions should be solicited. This type of resource is frequently overlooked by program developers. While an agency or group may not be able to provide funding to the effort, it may be able to contribute other valuable resources which can decrease the out-of-pocket cost of the program. In-kind contributions include staff and/or volunteers, bookkeeping assistance, space, medical or educational supplies, food, clothing, and other materials. Civic organizations such as the Junior League or the Kiwanis and Lions' Clubs may be able to provide some assistance. This support can be very helpful in putting a program together.

To undergird the in-kind contributions and to establish a secure financial base for the program, a vigorous fund-raising campaign should be initiated. Based on feedback from people with whom the proposed plan has been discussed, make appropriate revisions in the program; then seek commitments from all individuals/agencies who have expressed an interest in cooperating in this effort. Some potential funding sources will require only a brief proposal which outlines the program's goals and activities. Others will require a very detailed proposal. The specifications of each potential funding source must be met separately. The following items should be included in all proposals:

1. quantitative data on the population to be served and their unmet needs;
2. the proposed activities;
3. staff, i.e., resumes or a description of the background required for each position;
4. other resources to be contributed to this project through other agencies, organizations, etc.;
5. management plan;
6. evaluation design, i.e., what criteria will be used to assess the effectiveness of the program/services and the parties who will conduct the evaluation; and
7. budget.

Personal contact with potential funding sources can be useful. It creates an opportunity to discuss overall interests and priorities and to assess which activities can be of mutual benefit. It also helps establish rapport and a feeling of confidence in the staff seeking the funds. While proposals are generally evaluated on merits, a good relationship with the funding agency can help overcome any wariness or uncertainty that may exist about the proposed activities or the ability of the potential grantee to perform.

Commitments from other key organizations and agencies to help support some of the necessary services can strengthen the proposed program. While one agency may not be able to fund all the activities which have been planned, it may be able to provide some of the basic support required by the program. Community service organizations may be able to commit volunteers, supplies, space or funding and may welcome the opportunity to support a specific portion of the program or piece of equipment. As donations increase, more money can be targeted to the provision or expansion of priority services.

While a variety of sources can help to augment the funding for the program, this approach is not without liabilities. The most obvious one is the complexity of managing multiple funding sources, which can entail special documentation for each. Another problem is the continuation of such funding. Each may require its own proposal. Finally, keeping the funding agents apprised of the program, its continuing needs and its impact takes time. These liabilities can be overcome to a great extent with careful organization. For example, monthly reports, letters, or articles in newsletters could keep all the funding agents informed about the program. It is important to consider the assets and liabilities associated with multiple funding sources before seeking funds.

FOSTERING COMMUNITY SUPPORT

The timing of all these activities can be crucial in determing success. The climate for developing services for this population should be assessed throughout the previously-described steps. Feedback from public officials, local leaders, agency personnel, and civic organizations should be noted in trying to evaluate community readiness for a program. The local newspaper not only can serve as an indicator of the current climate but also can help set the tone for the proposed activities. The program's board of directors can play a key role in responding to public opinion and fostering public support.

If the feedback is positive, proceed with the plans and continue to cultivate support. While a community may endorse efforts on behalf of pregnant adolescents and adolescent parents at the initiation of a program, it is important to keep the citizens informed about the program's efforts throughout its development. Community support must be fostered on an on-going basis.

If the climate is generally neutral, it may be necessary to do some ground work to help the community understand the needs of its youth and how these needs might be addressed. The media can be particularly helpful. Talk to reporters, inform them of the issues, and help them develop feature stories. Human interest stories can draw the public's attention to needs in their community and can be very helpful in eliciting support. Be prepared to discuss what other communities are doing and how their programs might be adapted to local needs. Speak to volunteer and civic organizations, explaining how they might aid the effort. Continue to build community and neighborhood support as ideas for the program are developed.

On the other hand, if the climate in the community is negative toward providing services to pregnant adolescents and adolescent parents, it may be necessary to postpone the efforts or proceed more slowly. Try to identify the basis for the negative attitude as well as the key prople who oppose the services. If possible, meet with them, perhaps one-on-one, to discuss mutual concerns and philosophies and identify areas of agreement. Talk as well about the consequences of inaction in terms of self-sufficiency, minimum educational attainment, and health risks to both the adolescent mother and her child. It may be necessary to delay many of the other implementation steps until sufficient support has been generated in the community. Work with the media and enlist the aid of community leaders from civic organizations as well as schools and churches. While this may be a time-consuming process, it will generate strong support for efforts in the future. Whatever the community climate, there probably will be challenges to developing or expanding services and programs. To counter such reluctance, initiate and foster the expansion of the network of youth advocates. Evaluate the impact and cost of the program. Finally, take public relations very seriously because it is critical not only in the development but also in the continuation of services and programs.

IMPLEMENTING THE PROGRAM

Depending upon the success of the fundraising effort, it might be necessary to begin the program with fewer services than proposed. Many programs have begun on a limited basis and have subsequently expanded as greater support has been obtained. Program stability, sound management, positive evaluation results and effective public relations can facilitate program expansion.

When establishing new programs/services, it is advisable to allow sufficient planning time between the allocation of funds to an organization and the provision of services. This time should be used to establish operating procedures, hire and orient staff, prepare facilities, and communicate with other service providers. This process facilitates the smooth operation of the new program/services and should be built into the management plan of the proposal.

It is important to get outreach efforts to the target population underway at this time. There are many vehicles that can be used to reach youth directly: public service announcements on television or popular radio stations; flyers posted in places adolescents frequent; and ads in newspapers. Agencies and organizations where adolescents seek services, (e.g., counseling offices, health clinics) can display flyers about the program.

In conjunction with these activities, orientation meetings should be conducted with adults who work with youth to inform them about the services provided through the program, the client groups targeted, and the procedure for making referrals. The specific limitations of the program should also be discussed. In addition, explain the policy regarding feedback on referrals. Finally, learn what kinds of services they may be able to

provide to the program and its clients in order to strengthen the program's referral network. Publicity about the program is a method to reach potential clients, develop a strong referral network, increase recognition of the program and foster public support. It should be a carefully planned, on-going effort.

During this phase it is also important to review the evaluation mechanism, strengthening it wherever possible, particularly if program changes have been made since the proposal was written. To determine the impact of the program/services, the staff, board of directors and funding agents should know the basis on which the program will be assessed.

Considerable time, energy and resources must be invested to develop or expand services. Certain conditions make initiating and implementing services easier: relevant data, strong advocates, supporters with power, and available resources. In addition to these assets, the existence of a strong policy framework at state and local levels can rivet attention, resources and leadership which foster service development. Chapter 2 describes the policy development process and suggests agency policies which recognize the needs of and assure that services are provided to pregnant adolescents/adolescent parents. This chapter is provided not only to guide policymakers as they address the needs of this population but also to alert service providers to the policy development process.

CHAPTER TWO: POLICIES

CHAPTER TWO SUMMARY

Policies provide the framework for the provision of services. State level policies guide local level policies and practices, establishing standards for the provision of services.

Because adolescent pregnancy and parenthood have tremendous implications for the lives of those directly involved, their families, and society as a whole, human service agencies at the state level, particularly health, education and social service agencies, must address the needs of this population. The costs of not providing such services are astronomical in economic and human terms. Adolescents sixteen and under have an increased incidence of premature births, low birth weight babies, and maternal and infant mortality. Pregnancy is the most common reason young women drop out of school and their curtailed educations have a marked impact on their earning ability throughout their lifetime. The estimated cost of welfare to these families per year was almost half of the total welfare budget of $9.4 billion in 1975. To mitigate some of these costs, state and local governments should work together.

To assist agencies in doing so, it is suggested that state polices address the following areas:

- coordination of intra- and interagency efforts
- agency staff -- selection and responsibilities
- development of services -- those universal to health, education and social service agencies
- services specific to health, education and social service agencies
- data collection, dissemination and evaluation needs.

Eleven steps outline the policy development process: identify the problem; set goals; establish time lines; identify needed information; solicit constituency input; report progress; present first and second policy drafts; review final draft; adopt policy; and monitor, evaluate and revise.

Implementing policies involves several important activities: documenting the need for policies and services for this population, getting recognition for this population as a priority, seeking funding, assessing the political climate, developing advocacy efforts and utilizing technical assistance.

Thus, this chapter is designed to guide policymakers and service providers through the three major stages of policy development: rationale, development and implementation.

THE ROLE OF STATE AGENCIES

While government alone cannot resolve all the issues related to adolescent pregnancy/parenthood, government at the federal, state and local levels can help to establish and improve programs and policies to better serve the needs of young people who are at risk of pregnancy or who are already involved in early pregnancy/parenthood, as well as the needs of their families.

RATIONALE FOR HEALTH AGENCY INVOLVEMENT

Pregnancy and childbirth are life events that have always been attended by some risk. When teenagers become pregnant, however, the circumstances of their chronological and developmental ages greatly increase the potential for difficulty or even tragedy. Among the problems which frequently result from early pregnancy and parenthood are those related to physical health. In the United States, studies have shown that adolescents sixteen and under have an increased incidence of prenatal complications, premature births, maternal and infant mortality, and infant morbidity. The younger the adolescent, the greater the health risks to the fetus.

While several established federal categorical health programs fund services needed by other special target populations, funding of services for pregnant adolescents has only recently been made available on a categorical basis and these funds are very limited. Thus, state agencies must draw upon many resources which are not, in fact, specifically targeted to pregnant adolescents and adolescent parents in order to provide needed health care. The limited federal and state support for this target population makes it highly desirable for state health agencies to work as closely as possible with state education and social services agencies, as well as other entities, to coordinate efforts and to share resources.

RATIONALE FOR EDUCATION AGENCY INVOLVEMENT

Research also has demonstrated the adverse effects of early pregnancy/parenthood upon the education and future employment of the adolescents involved. Pregnancy seems to be the the most common reason young women drop out of school, and this curtailment or interruption of education results in decreased development of skills and ability to be self-supporting. Young fathers also may face curtailed or interrupted educational opportunities, limited employment prospects, and economic and child rearing responsibilities for which they are unprepared. Pregnancies, chronic unemployment, and the demands of caring for small children create a cycle of economic dependency which is difficult to interrupt.

To prepare young people for adulthood and to furnish them with a comprehensive education, schools have a responsibility to provide students with information on the responsibilities of parenthood. Through this education, and by referring young people to needed health and social services, the educational system can play an important part in preventing premature parenthood.

RATIONALE FOR SOCIAL SERVICE AGENCY INVOLVEMENT

While adolescence is a developmental stage often associated with strained relationships between parents and youth, adolescent pregnancy/parenthood creates additional financial and psychological stress in most families. Community and social service organizations can provide counseling, referral to health and education agencies, and access to material resources such as housing, payment for medical care, financial subsistence and nutritious food. This support helps to mitigate the stress experienced by individuals and families when a teenager becomes pregnant or a parent.

RATIONALE FOR AN INTERAGENCY APPROACH

Because pregnant adolescents/adolescent parents have special health, education, social service and other needs, it is advisable for agencies from these fields to work together. If the many agencies responsible for these services work together through an interagency committee to develop, coordinate and strengthen policies and services, a number of benefits could result. First, personnel from the participating agencies would understand the role, goals and services of other agencies better. This increased awareness could lead to the identification of gaps and duplications in the provision of services, and appropriate changes could be made, resulting in more effective, efficient and economical policy and service approaches. Second, at the service provision level, adolescents would be more likely to receive referrals to other agencies for services they need. Follow-up to facilitate and monitor contact with other agency(ies) would be more likely to occur. Thus, adolescents can be better served through interagency efforts.

Because an interagency approach can strengthen the policies and services to these adolescents, it is strongly recommended. To assist individuals and agencies who are interested in this approach, Chapter Three provides guidance on developing and managing interagency collaboration.

The Suggested Policies which follow were developed with the assistance of experts on the NASBE Adolescent Parenthood Advisory Panel and have been reviewed by personnel in state and local agencies who are familiar with policies and/or programs related to adolescent pregnancy/parenthood.[1] The policies are presented for consideration by states, particularly their health, education and social service agencies. Other agencies with responsibility for meeting the needs of this population are encouraged to participate in the state effort and to adopt an agency policy framework. These policies can serve as a guideline for what might exist.

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1 The NASBE Advisory Panel met twice over a 16-month period to develop and refine these policies. Opportunity also was provided later for review and feedback. Then the policies were field tested by interviewing over 130 people at the state and local levels about these policies and the changes needed to make them feasible in their jurisdictions.

States are encouraged to assess their current efforts in this area to determine policy strengths and weaknesses. Many states already have some of these policies in place while others may have adopted portions of them. The assessment of existing policies and efforts and a determination of what steps can and should be taken next are critical steps in the process. The Suggested Policies can provide guidance in charting future efforts; they can be adapted as necessary to meet unique circumstances in a state.

POLICY DEVELOPMENT PROCESS

SETTING PRIORITIES

In the development of a state policy framework, a most critical aspect of the process is that of setting priorities for policy development and implementation. In this process the following issues should be considered:

1. What policies already exist that directly affect the provision of services to pregnant adolescents/adolescent parents and to adolescents in general? Are these policies effective? Do any need to be changed? How? What specific steps need to be taken to make these changes?

2. What are the most pressing needs of this population? Are these needs addressed through the policy framework? If so, is it adequate? If not, what can be done to correct this situation?

3. What resources already exist that could be directed to meet the needs of this population? Are they being used effectively? What resources are not presently available? How could these gaps be addressed?

4. What are the long range goals for the state agencies? Do services to pregnant adolescents/adolescent parents fit into these goals? If not, how can they be incorporated?

Some states have chosen to focus on adolescent parents and parents-to-be, while others have elected to address this population within the context of a different issue such as infant mortality, child abuse, or the special needs of youth. Whatever issue is the priority, it is critical that the needs of these teenagers be addressed if the health, education, social and other aspects of their situation are to be dealt with effectively.

ELEVEN STEPS

Establishing or changing a policy is a multi-stage process that involves policymakers, agency staff who have responsibility for implementing the policy, as well as those affected by the policy--local service providers and constituents. To establish policies it is important to undertake a process of systematic review and development. To help policymakers and service providers in this effort, an 11-step procedure for policy development is outlined below. This model has been used effectively with policymaking groups and can be adapted easily to the individual procedures of an agency.

The Steps Outlined

Step 1	Identify the Problem
Step 2	Set Goals
Step 3	Establish Time Lines
Step 4	Identify Needed Information
Step 5	Solicit Constituency Input
Step 6	Report Progress on Data Collection & Constituency Input
Step 7	Present First Policy Draft
Step 8	Present Second Policy Draft
Step 9	Review Final Draft
Step 10	Adopt Policy
Step 11	Monitor, Evaluate and Revise

Step 1: Identify the Problem

The first step is simply to recognize that the need for a new policy exists, or appears to exist. At this point policymakers must decide whether the issue seems to warrant any further discussion. If it does, they acknowledge this need and schedule the issue as a specific item for an upcoming work session.

Step 2: Set Goals

The goal-setting work session is the single most important phase of the development process. Its purpose is to make sure that everyone involved in the policy process understands why the new policy is needed. A number of key questions must be raised: What are the goals of the policy? What will the impact be? Who will be affected and how will they react? Who should be consulted during the development process? How will the policy be implemented? By the end of this first work session the policymakers should be able to state, in writing, what the goals and objectives of the policy are and how they plan to achieve them.

Step 3: Establish Time Lines

After it has been decided what steps are needed to develop the policy, the policymakers must establish a realistic timeframe for reaching the various objectives, beginning with the date they would like to see the policy formally adopted. When this date has been set, the policymakers should also specify deadlines for work sessions, data gathering, and progress reports.

Step 4: Identify Needed Information

During (or shortly following) the first work session, the policymakers must decide what kinds of information are needed before any drafts of the policy can be written. This data-gathering should include a description of the state-of-the-art; a review of existing research; and a summary of similar policy actions around the country.

Step 5: Solicit Constituency Input

Another valuable source of information will come from those constituencies which will be affected by the policy. The policymakers may decide to ask for written comments, or to establish ad hoc task forces, or to hold formal hearings on the issue. Whichever route is chosen, it should be scheduled as early in the development process as possible.

Step 6: Report Progress on Data Collection and Constituency Input

Before the first drafts of the policy are written, the policymakers should receive a detailed progress report on the results of the data collection, including any feedback from the various constituency groups. The policymakers should review this report in light of the goals and objectives outlined earlier, to determine whether the new data is compatible with those earlier projections. If not, the policymakers may decide to follow an alternate approach.

Step 7: Present First Policy Draft

The purpose of the first policy draft is to give the policymakers a full range of available options, along with the information they need to make a wise decision. Accordingly, the first policy drafts should include the following support documents: a statement of the rationale for the policy; a timeline for implementation; a statement detailing how and when the policy will be evaluated; a description of possible political consequences; a projection of what the constituency reaction will be. In the case of a particularly sensitive issue, substitute language or even entirely separate policy drafts should be prepared, each with its own support documents. The policymakers are now ready to discuss the drafts and to suggest any appropriate changes.

Step 8: Present Second Policy Draft

The second policy draft is a polished statement incorporating all the changes suggested during the previous work session. It should also include: a statement clearly outlining the goals of the policy; a statement detailing the rationale of the policy and its objectives; a statement saying how the policy will be implemented, including a specific date when the policymakers will be given an evaluation report. Other than some minor fine-tuning of language, the policymakers are now ready to adopt the policy, unless they decide they need additional information or feedback.

Step 9: Review Final Draft

In those cases where more data are needed, the policymakers may decide to revise the policy language to reflect this new information. Otherwise this step can be eliminated.

Step 10: Adopt Policy

The policymakers are now ready to formally adopt the policy. Hopefully this will occur on or around the target date established months earlier.

Step 11: Monitor, Evaluate and Revise

Once the policy has been adopted, it is up to the chief executive officer to monitor its impact and to furnish the policymakers with interim progress reports at specified dates. Finally, within one to three years, a complete evaluation of the policy's effectiveness should be provided to the policymakers.

SUGGESTED POLICIES

UTILIZING THE SUGGESTED POLICIES

Persons interested in serving the needs of pregnant adolescents and adolescent parents are encouraged to provide the most comprehensive policy framework and the best programs possible. However, not every agency or state will be able to adopt a comprehensive policy framework at the outset. The inability to do so should not deter efforts to establish or expand policies. A partial policy framework, fostering the delivery of a few services and giving limited priority to the needs of the target population, is often more desirable than no policies at all. Although an outside observer might find the services deficient, limited policies and programs can begin to draw attention to the special service needs of pregnant adolescents, their partners, and adolescent parents and their families. This visibility will provide a foundation for future expansion of policies and programs.

The Suggested Policies have been grouped under the following headings: Coordination; Staff; Development of Services, including separate listings for health, education and social service agencies; and Data Collection, Dissemination and Evaluation.

COORDINATION

1. The state agencies shall* create and/or maintain a permanent inter-agency body at the state level whose functions will be to:

   - assess the nature of the problems associated with adolescent sexuality/pregnancy/parenthood in the state;
   - develop agreements on mutual goals, allocation of staff, provision of services, and each agency's role and function in providing multi-disciplinary services to young women and men at risk of early parenthood;
   - provide information to the public--especially parents and youth--about adolescent development and behavior, and the extent of adolescent sexual activity, pregnancy and parenthood;
   - inform the public about existing services for adolescents at risk of early pregnancy, through brochures, public service announcements, etc.;
   - develop and implement a course of action to be facilitated by the responsible agencies; and
   - maximize exising financial resources as well as seek internal and external funding sources to implement that course of action.

* "Shall" is used in these policies to suggest what ought to or must be done, in keeping with language used in laws, regulations and other policy statements.

The interagency body shall be structured to include both those who have decision-making responsibility as well as those charged with implementing agency policies and practices in this area.

To assist the state agencies in these efforts, local personnel who serve pregnant adolescents/adolescent parents shall help identify priorities, resources and personnel.

The local counterparts to these state agencies shall help to create and/or maintain similar interagency committees at the local level, composed of professionals, representatives of the community, and youth.

2. To provide coordinated, comprehensive services to the target population, the state agencies shall work with other agencies engaged in youth-related services to establish agreements addressing mutual goals, the provision of services, and a client referral and follow-up system. These other youth-serving agencies include housing, juvenile justice, labor, mental health, parks and recreation, substance abuse, transportation, and vocational training.

STAFF

3. Each state agency shall designate staff responsible for developing and implementing policies, providing training, and coordinating state level services and activities to meet the needs of the target population. In addition, local counterparts to the state agencies should assign a staff person responsibility for this area.

4. The state agencies shall select staff on the basis of expertise as well as interest in and concern for the needs of the target population. The staff also should be aware of and responsive to the cultural, ethnic, religious and/or value differences of the target population(s).

DEVELOPMENT OF SERVICES

5. The state agencies shall encourage the provision of outreach services for adolescents, such as peer counseling and public service announcements and brochures that provide information on available resources and services in the community.

6. The state agencies shall provide technical assistance and training to state and local program personnel who are involved in this issue.

7. The state agencies shall set minimum standards for the provision of services which meet the special needs of pregnant adolescents/ adolescent parents. Internal and external assessments of service delivery programs shall be conducted periodically.

8. The state agencies shall involve lay citizens, including parents of adolescents, adolescent parents, and young adults in the policymaking process and in the development of programs designed to meet the special needs of this population.

9. The state agencies shall enter into purchase of service agreements relevant to the provision of services to pregnant adolescents, adolescent parents and their families only with those agencies that comply with provider requirements; have established reasonable costs for the services they are to provide; and can assure that the services are provided by competent staff.

Services Provided and/or Administered by the Health Agency:

10. The state health agency shall encourage the provision of comprehensive health services for young women and men at risk of early pregnancy/parenthood, pregnant adolescents, their partners, and adolescent parents and their families. The agency shall work with other state agencies as well as service providers in the development of the services.[1]

11. The state health agency shall assure the provision of preventive and primary reproductive health care to adolescents through direct services, funding, or referral to other agencies/service providers.

12. The state health agency shall ensure the provision of services regardless of sex, age, race, national origin, citizenship, residence (specific consideration for geographic area), or handicapping condition. Services shall be provided to adolescents based solely on the informed consent of the individual and in accord with the principles of confidentiality. Adolescents shall be encouraged to involve their parents and assistance in helping them do so shall be provided as appropriate.

Services Provided and/or Administered by the Education Agency:

13. The state education agency shall encourage local education agencies to develop and/or maintain special services to meet the comprehensive education needs of pregnant adolescents, their partners, and adolescent parents. The state agency shall provide technical assistance to local

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[1] The Adolescent Parenthood Project Advisory Panel and Task Force have recommended that the following health services be available: family planning; pregnancy testing; counseling on and health services relating to pregnancy (abortion or carrying the pregnancy to term with the subsequent options of adoption or raising the child); services related to genetic diseases as appropriate; sexually transmitted disease treatment; nutrition information and services; care related to pregnancy; interconceptional care; care for infants; general health care screening and treatment; dental screening and care; child development information and parenthood education; and referral and follow-up to education, social services, and other appropriate agencies.

agencies in the development of comprehensive instructional programs and educational services for the target population.[2]

14. The state education agency shall encourage the local education agencies to provide career awareness education and counseling, including job skills training, job counseling/career exploration and job referral/placement opportunities as part of the comprehensive services for pregnant adolescents/adolescent parents, to assist them in achieving economic self-support and personal self-sufficiency.

15. The state education agency shall require that decisions regarding whether to remain in regular school or to transfer to an alternative educational program be made by the student. The student shall be encouraged to involve her family in making this decision. A physician's recommendation should be considered when appropriate. The state agency shall review the local education agencies' practices to assure that pregnant adolescents/adolescent parents are being provided the same educational and extra-curricular opportunities as other students.

16. The state education agency shall require the local education agencies to encourage adolescents to continue in school during pregnancy and to return to school after delivery. The local agencies should seek out adolescent parents who have withdrawn and encourage them to return to school. Counseling should be provided to assist adolescent parents in returning to or staying in school.

17. The state education agency shall adopt a sequential curriculum for family life and parenthood education, including human sexuality, which may be required of/adopted by the local education agencies. The state education agency shall involve representatives from the local level and professionals from other fields in the development of this curriculum. The curriculum shall begin as early as possible, tailored to the developmental level of the students involved, and shall be reviewed regularly by appropriate groups. It shall be available to all students; however, parents shall be allowed to excuse their child(ren) from this instruction.

    Training and certification in this area shall be required for all family life and parenthood education instructors. The state education agency shall ensure that adequate training is available.

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2 The Adolescent Parenthood Project Advisory Panel and Task Force have recommended that the following educational services be available: standard education courses; counseling; education on child development, parenthood, nutrition, decision-making, and employability skills; infant and child day care; and referral and follow-up to health, social services and other appropriate agencies.

18. To assist adults in their role as parents, the state education agency shall encourage local education agencies to promote and assist in the development of parenthood education in or out of school settings, to provide all parents with information about child development and to assist parents in understanding the special needs of their child(ren). The state education agency shall encourage the development of parenthood education programs through the elementary/secondary schools or through other community institutions such as community schools, adult education programs, parent-teacher-student associations, churches, civic groups, health clinics, social service agencies and community colleges.

Services Provided and/or Administered by the Social Service Agency:

19. The state social services agency shall assure that young women and men at risk of early pregnancy/parenthood, pregnant adolescents, their partners, and adolescent parents and their families who are in need of services have access to assistance which is necessary to achieve economic self-support, personal self-sufficiency, the prevention of abuse, neglect or exploitation of the family unit, and other comprehensive services.[3]

20. The state social services agency shall give priority, through the Comprehensive Annual Services Plan (Title XX), to the needs of adolescent parents and their families with particular emphasis on infant/child day care and family planning services.

21. The state social services agency shall ensure the provision of services regardless of sex, race, national origin, citizenship, residence, age, handicapping condition or marital, pregnancy or parenthood status. Services shall be provided to adolescents based solely on the informed consent of the individual and in accord with the principles of confidentiality. Adolescents shall be encouraged to involve their parents and assistance in helping them do so shall be provided as appropriate.

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[3] The Adolescent Parenthood Project Advisory Panel has recommended that the following social services be available: adoption; counseling regarding birth control, human sexuality, abortion, adoption, marriage and family, parenthood, employment and education; education regarding child development and parenting skills; emergency shelter; financial assistance leading to self-sufficiency, including information about eligibility requirements; foster care; health services to include hospitalization; infant and child day care; job readiness training and job placement; legal assistance; protective services; respite care, including day care and homemaker services; and referral and follow-up to health, education and other appropriate services.

DATA COLLECTION, DISSEMINATION AND EVALUATION

22. Data shall be collected about the target population as well as those adolescents served by each state agency. The data shall be collected using a standard reporting form developed on a collaborative basis with other members of the interagency body. The right of confidentiality of the individuals concerned shall be protected.

23. The state agencies shall encourage research and evaluation activities regarding the provision of services to this population so that (1) a knowledge base may be established/expanded regarding the effectiveness of existing and new programs and (2) direction for future efforts may be provided. The evaluation findings shall include recommendations for policy, program and research efforts.

POLICY IMPLEMENTATION

Policy development sometimes sparks controversy. When opposition is anticipated, proponents must expect to undertake additional efforts and strategies to defend and promote the needed policy. Draft registration is an obvious example of a recent federal policy change that sparked wide attention from the media, action and comment from many young men directly affected by it, and debate within Congress and among the public at large. Frequently policy implementation at the state level also generates considerable attention because vast numbers of people are affected by it and because those people hold a wide range of views about the relative merits of the policies in question. When the policy issue is especially sensitive, the implementation process becomes more complex and therefore warrants special care and consideration.

This circumstance is more the norm than the exception when implementing policies concerning pregnant adolescents/adolescent parents. Therefore, this section has been developed to serve two purposes: (1) to identify key considerations in public policy development and implementation; and (2) to describe in some detail those considerations in state policy implementation which relate to pregnant adolescents and adolescent parents.

Many approaches to policy implementation have been tried and tested over the past several years at the federal, state, and local levels. Each of the implementation strategies to be discussed in this paper has been tried at different times in relationship to pregnant adolescents/adolescent parents. However, because formal policies affecting these groups are in the early stages of development, few states have had the opportunity to apply the strategies in a comprehensive manner.

Implementing policies to address the needs of these adolescents should be approached systematically. Though not foolproof, the following steps can be regarded as a road map to success. Each of these important activities is described in detail below.

1. Documentation of need
2. Recognition as a priority
3. Establishment of funding base
4. Assessment of political climate and timing
5. Identification of advocates and initiation of advocacy efforts
6. Utilization of technical assistance

DOCUMENTATION OF NEED

An ititial step in implementation is to determine the approximate number of young people and extended family members directly or indirectly affected by early pregnancy, parenthood, and/or other circumstances pertaining to sexuality. While the accuracy, scope, and currency of data vary in this regard, an approximation of the size of the population helps establish a rationale for policy development. Without this information, it is extremely difficult for policymakers to measure the relative demands of this population on the state human services system in comparison to the competing needs of other groups.

When gathering and organizing the data for presentation to policymakers, some key questions need to be answered if decisionmakers are to understand the information and use it most effectively to create a policy rationale. For example, policymakers need to know--with some precision--how many pregnant adolescents presently are being assisted through the state health, education, and social services agencies. Among the questions to be answered are:

1) Is current data related to adolescents available?

2) How many young women under the age of 18 delivered babies during the past year (or the most recent year for which information has been tabulated)? Had miscarriages or abortions? What is the estimated number of sexually active adolescents?

3) How many female students are reported to have dropped out of school for reasons of pregnancy and/or marriage during the most recent year on record?

4) How many women under 18 are receiving AFDC as a result of their status as a parent?

While these questions are not exhaustive, they illustrate the scope of issues to be considered when developing a multidisciplinary policy implementation process. In addition, documenting the need requires a careful review of existing service delivery systems to determine what is presently being done for pregnant adolescents and adolescent parents and whether or not these services are effective. Because there is competition among human service programs for fewer dollars, the documentation of comparative need and publication of program results becomes increasingly important as a means of justifying policy support and funding.

RECOGNITION AS PRIORITY

After data on the population have been compiled, the task will be to determine what policies are needed to assure the delivery of comprehensive services. The Suggested Policies set forth by NASBE's Adolescent Parenthood Project can serve as a guideline during this assessment and development process. They can be implemented in a variety of ways ranging from full adoption and implementation involving cooperative efforts among several agencies to partial adoption of selected policies by only one agency.

The key to eventual implementation of any policies depends largely upon making this target population a priority. Invariably arguments will be raised against policies for pregnant adolescents and adolescent parents because "there aren't enough of them." This argument has been effectively countered in some states through the promotion of policies and programs which affect much broader populations but which take into account the needs of adolescent parents.

As an example, the Kansas legislature appropriated funds in 1978 for the establishment of a Parent Education Resource Center. The Center, which is administered by the Kansas State Department of Education, collects information about the description, location and availability of parenthood education programs and materials and makes this information available to school districts, groups, and individuals. In the statement of purpose developed by the Governor's Commission on Education for Parenthood which promoted the idea of the resource center, the target population was all parents whether expectant, adoptive, foster, single, or divorced as well as people who work with children on a professional or paraprofessional level. By encompassing virtually all parents who are in special circumstances, the state of Kansas was able to establish a resource that is helpful to adolescent parents as well as to others. If the Resource Center had been proposed for adolescent parents only, it is possible that their aggregate number might not have been large enough to gain the attention and commitment of the legislature.

Pregnant adolescents and adolescent parents became a policy priority in New York in a different way. In his 1978 State of the State message to the Legislature, Governor Hugh L. Carey cited adolescent pregnancy as one of the most compelling concerns facing the state. To deal with the problem, the Governor asked the Department of Social Services to work in concert with other state agencies to ensure that adequate services were made available to pregnant teenagers and young mothers and that appropriate family planning services were made available for other adolescents. As lead agency, the Department of Social Services appointed a Task Force on Teenage Pregnancy which developed a set of recommendations that spoke to the needs of the pregnant adolescent in addition to the young person at risk of pregnancy. The state agencies and legislature, in a unique demonstration of state agency collaboration, acted on the recommendations soon after they were presented and implemented some projects through special appropriation measures. The role of Governor Carey illustrates the importance of engaging key decisionmakers in the issue as a means of fostering policy developments.

The process of establishing priorities also can be influenced by initiatives or mandates imposed by legislatures, regulatory bodies or state and federal agencies. For example, a state health department could designate adolescent health as a priority. Such an effort could serve as a preliminary building block to the development of an overall agency policy on adolescents which could include concern about the health of pregnant teenagers. Such an initiative could encourage further policy action as well.

An example of an existing federal policy that applies to this population is Title IX of the Education Amendments of 1972 which prohibits discrimination on the basis of sex in federally funded education programs. Section 86.40 of Title IX specifically addresses possible discrimination against pregnant adolescents, married students, or students who are already parents. This document can be used to ensure that the rights of pregnant adolescents, adolescent parents, and/or married students are protected. While policy statements do not necessarily translate into dollars for services, they do substantiate the needs of this group and can lead to funding.

Another way to begin establishing this population as a priority is analyzing the implications for a state if policy initiatives are not acted upon. Who will be affected? Is the effect affordable in human terms? In terms of dollars? Would the effect be more detrimental with a new policy in place than with the status quo? If current trends continue, what are the short and long-term effects of adopting these policies? What will happen if policies are not adopted? Is there enough evidence in the state or from other states to chart a course of action? The answers to these and other key questions will help guide decisionmakers and aid them in gaining an understanding of a complex issue.

In most cases, policies foster the provision of services to these adolescents and provide a model for local communities to follow. However, in some states, policymakers have themselves admitted that the complete lack of a policy constitutes a helpful policy because there are no discernible governing constraints which could limit supportive services to pregnant adolescents and adolescent parents. A careful assessment of the climate for the development of policies for this population should be made. In cases where policies would restrict rather than enhance services, policy development should be postponed.

As described, making pregnant adolescents and adolescent parents a priority is a mini-process within the overall process of policy development and implementation. The options identified will not necessarily lead to similar ends given the diversity among states. However, the recognition of this population as a priority will establish a climate responsive to their needs.

FUNDING

Often the first question asked by policymakers as they consider the issue is: What will this policy action cost? Estimates of costs must take into account a variety of factors, including staff, equipment, facilities, services and the number to be served. Before estimating the cost of these components, it is critical to assess the cost of implementing previous, ongoing and related policies.

Depending on current efforts, the policy changes under consideration may not incur significant additional obligations for the agency in terms of staff or other administrative expenses. It is possible as well that another state agency(ies) may be willing to commit some resources which would lessen the expense. Perhaps resources can be drawn from the federal government or the state legislature. While generating these resources is time consuming, it helps establish the basis for a secure program.

In the 1970s, precedents for initiatives on adolescent pregnancy were established at the federal level as well as in several states. The federal government launched their initiative in 1977 through the Department of Health and Human Services (then Department of Health, Education, and Welfare). While it called for new legislation and new appropriations, it also suggested reprogramming existing dollars from some programs that had related legislative mandates but which had not established adolescent pregnancy as a priority. Both strategies--new legislation and funding, and reprogramming--are options for consideration in developing new or expanded policies.

Given the current economic situation, it is probably wise for states to exhaust the possibilities for reprogramming existing resources before launching a new legislative and funding package. If new legislation is indicated, generating revenue through supplemental budget packages and/or amendments to existing legislation may be possible. Such funds could support the development of a program initiative.

When policymakers try to assess the costs of a policy framework, the following questions may be helpful. The answers should be based on data from the most current reporting year.

1. What is the fertility rate among adolescents? What is the birth rate? What is the cost of providing prenatal care to an adolescent? What is the cost of providing family planning services to an adolescent? How much money has been expended to provide these services to adolescents on an annual basis in recent years?

2. How many adolescents dropped out of school because of pregnancy or marriage? How much money is lost to local districts as a result of these dropouts? What, if any, is the additional cost of keeping these adolescents in school?

3. What eligibility requirements must a pregnant adolescent or adolescent parent meet to receive AFDC? What is the cost of providing AFDC to an eligible teenager? How much AFDC money was expended for pregnant adolescents/adolescent parents?

4. How many adolescents used Medicaid to pay for labor and delivery costs? What is the cost of providing these services?

5. What percent of adolescents in need of services actually use them? What costs may result later when they and/or their children do not receive services?

Answers to these and similar questions would enable policymakers to estimate the cost of a policy. It is particularly important to assess:

- the cost of providing a service to an adolescent;
- the number of adolescents who meet eligibility requirements; and
- the percent of adolescents in need who would actually request the service(s).

In addition, it is important to know if these services are already being provided to other populations and what additional cost there would be, if any, of extending them to adolescents. Another question to be answered is the number of teenagers who are not being served and what it would cost to reach them. These questions illustrate the kind of information-gathering that must take place when assessing the cost.

Collaborative approaches across agencies can disperse the cost of services and encourage their provision. One delicate issue which can arise regarding some collaborative efforts is the exchange or transfer of funds from one agency or group to another. In some cases, a once clear agreement about jurisdiction over funds and administrative lines of authority can become a problem area. To avoid these circumstances, an assured legal basis for the collaboration is helpful. With or without a legal base, the responsibilities of all the principal agencies need to be developed, approved and executed with the ultimate goal of serving the clients most effectively.

The final and perhaps the most difficult assessment which must be made is the estimated cost of not providing the service. Failure to provide services for adolescents during pregnancy or early parenthood may lead to much higher costs in the long run in terms of welfare dependency, an inability to find employment, and/or offspring who are more likely to have health problems or be developmentally delayed. All these complex issues must be addressed in the cost-benefit analysis process.

POLITICAL CLIMATE AND TIMING

Because adolescent pregnancy is a sensitive issue, the political circumstances within local, state, and federal government agencies should be considered. On the federal level, a wide scope of activities are underway in 1980-81 in the Departments of Health and Human Services, Labor, Education, and Agriculture, to name only a few. Most of these agencies are supporting research, service, and/or demonstration projects in different parts of the country. The services provided by these programs tend to vary within states, with some communities providing extensive services while others offer very limited services.

Political climate and timing can be affected by media coverage. If implementation of policies such as those suggested receives media attention, it can be a tremendous advantage to advocates, providing they have taken the time to brief the press. It is equally important to counter erroneous statements and reports that appear in the media. To assist in this process, public information offices in state agencies should be encouraged to foster a receptive climate for the policies. When public relations programs are carried out carefully and systematically, the public and policymakers become better informed on the issue and, ultimately, better prepared to make sound judgments about future directions in public policy.

Support from politicians should be elicited. It is important to communicate with legislators, learn their views, and identify those who might be willing to sponsor legislation and/or promote legislative changes. Support from the governor should be sought as well. More women have achieved elected offices in state legislatures and their receptivity to the adolescent pregnancy issue has become more visible. This circumstance may also contribute to a better overall political climate and should be taken into consideration when developing a political strategy for implementing any proposed policies.

In assessing overall political climate and timing it is important to understand existing relationships among state agencies as well as with the state legislature and the governor. The NASBE policy study revealed that at this time nearly all states have at least informal relationships, direct and indirect, between two or more principal agencies with responsibility for serving pregnant adolescents. Informal ties between agencies, when adequately nurtured by staff and policymakers, can lead to expanded, formalized relationships which eventually may involve other agencies as well.

It is important to cultivate relationships with legislative committees and governor's staff on this issue because these people establish fiscal priorities. A variation on this theme involves support from the spouses of legislators and governors. While it should not be inferred that adolescent pregnancy and parenthood are only women's issues, it is true that many prominent women have taken active roles in this area, and most spouses of policymakers at these levels are women. This issue can be introduced to them with an eye toward inspiring their leadership in state activities.

The compelling problems associated with adolescent pregnancy and its dramatic impact on families often evoke a commitment to this population. To generate this commitment and utilize it in support of a comprehensive policy framework, key individuals must be systematically involved in the process. Political circumstances--the climate, timing and personalities of key policymakers--must all be factored into the policy implementation equation.

ADVOCATES AND ADVOCACY

Advocates and Advocacy. These two words are potentially explosive because historically they have been tied to confrontation. However, advocacy means "pleading a cause" and effective advocacy efforts on behalf of pregnant adolescents/adolescent parents have been informative, persuasive and helpful, rather than confrontive, in nature. The Suggested Policies proposed in this document will remain just that--suggested--unless advocates are successful in guiding them through the complicated bureaucracies which govern state policymaking. Advocacy efforts can help bring the policies to life and can assist in incorporating them into the state framework. Because effective advocacy efforts are so important, several guiding principles are suggested here.

To be effective, an advocate must be knowledgeable. When advocating for policy development, it is important to be familiar with this process as well as the area of teenage pregnancy. There are a number of resource persons who already possess expertise in both areas. Their assistance should be solicited to train others as well as to aid in the current advocacy effort. If no such advocates are available, persons who know the policy development process should engage in a mutual learning process with those who are knowledgeable about this issue. Working together, they can become effective spokespersons for policies related to pregnant adolescents/ adolescent parents.

Matching the advocates(s) to the entity being lobbied is very helpful. For example, a representative from an education program may be more effective in communicating with representatives from the education agency. This example applies to health and social service agencies as well.

Similarly, the information provided by advocates should be tailored to meet the interests and concerns of the people they are lobbying. While the counseling needs of pregnant adolescents/adolescent parents may be of interest to health agency representatives, information on the special health risks of and services needed by this population would be more compelling. To the extent possible, advocates should tailor the information for maximum impact on the intended audience.

When identifying potential advocates, it is helpful to think about existing groups which may already be motivated to work on behalf of the target population. There may be government agencies that are very interested in supporting this issue, such as a Governor's Committee on Adolescent Needs, or an agency division such as Maternal and Child Health. Their support and involvement should be solicited.

In addition to identifying appropriate, trained advocates, it is necessary to look at two other issues: Who should be lobbied? When should the efforts begin? These questions must be answered on a case by case basis after assessing the policies that are being proposed, the process that will be followed, and the key policymakers who will be involved. Then an advocacy plan can and should be developed.

TECHNICAL ASSISTANCE: AN AID TO POLICY IMPLEMENTATION

The complexity of policy implementation--especially in a sensitive issue area--cannot be overestimated, but it need not stifle the effort. The creative use of the resources for technical assistance developed in the human services field over the past several years can help avoid or overcome difficulties associated with policy implementation. Fundamentally, technical assistance is practical help to reach an identified objective.

Technical assistance may address a myriad of needs and may take many different forms. Consulting others who have already developed and implemented policies in this area may be most helpful. Perhaps information on working with the media is needed, or suggestions on how to use existing data systems to collect information on this population. Based on the needs, assistance could be provided through phone calls, meetings, interviews and workshops. Whatever the issue, it is beneficial to seek and use resources that can meet the current technical assistance needs.

CONCLUSION

Frequently people fail to realize the importance of a policy framework for providing services. In the past, many advocates have been successful in establishing community-based services to youth without benefit of state-level policy support. While these efforts are to be applauded, they have not generally led to systematic state-wide efforts. Thus, teenagers in one

community may receive services while those in another receive none. A state policy framework can lead to a state-wide effort, reducing or eliminating a piecemeal approach.

Policy development and implementation should involve consumers, program personnel and policymakers. Each group should help formulate the policy(ies) to ensure that what is adopted is responsive to the needs of the target population. A systematic approach to addressing the needs of pregnant adolescents/adolescent parents is necessary if a strong policy framework is to be adopted and implemented.

CHAPTER THREE: INTERAGENCY COLLABORATION

CHAPTER THREE SUMMARY

Webster defines collaboration both as "cooperating with an agency or instrumentaility with which one is not immediately connected" and as "cooperating with or willingly assisting an enemy of one's country." While this chapter is based on the former definition, collaboration is often approached by those involved as if they are working with an enemy. Such a negative attitude by participants can retard, if not undermine, all efforts.

This chapter seeks to make the process of collaboration easier by discussing the important steps in initiating and managing collaboration. Understanding each agency's abilities, functions and goals is a beginning step in this process. The facilitator plays a pivotal role in this process as s/he unites the many individuals and organizations involved in pursuit of a common goal. For effective management and time utilization, a two-tiered committee is recommended: the agency heads comprise one level and are responsible for providing leadership, resources and decision making; agency personnel who have been selected to represent their agencies comprise the second level and they work together to develop and implement plans and activities approved by the agency heads.

In managing collaboration, such issues as setting realistic goals and allocating the necessary resources to plan and execute the activities are discussed. The role of the facilitator includes delegating the tasks, providing adequate direction, and following up on these efforts. Another important element of a collaborative effort is the establishment of a mechanism to keep the members informed about on-going activities.

It may be appropriate to develop written interagency agreements which secure the commitments and delineate the responsibilities of the participating entities. While such agreements can solidify collaborative activities, they must be approached carefully, making certain that the process of developing the agreement does not become destructive rather than constructive.

Of particular importance at the local level is the establishment of a case management system to assure that pregnant adolescents/adolescent parents do not "fall through the cracks" as they move from one service provider to another. Barriers to collaboration such as interpersonal and interagency strife, lack of resources, and failure to document the impact of the efforts are discussed.

Finally, six case illustrations are provided, three at the program level and three at the policy level. Two successful and one unsuccessful efforts are described to provide further guidance based on the actual experiences of several collaborators.

To unite people from different areas of expertise and agencies to establish and accomplish mutual goals is the essence of collaboration.

INITIATING COLLABORATION

Service delivery to pregnant adolescents and adolescent parents can be substantially improved through the cooperation and assistance of state agencies. One agency alone cannot provide the scope of services needed by these young people and their families. But beyond the necessity for coordiation, when state agencies work together to meet the needs of a particular group, mutual priorities can be identified and means to address joint goals and objectives can be interwoven, creating a much stronger effort. In addition, a strong interagency effort at the state level encourages and facilitates similar efforts at the local level. Local agencies are better able to establish comprehensive referral mechanisms, eliminate service duplication, identify and respond to gaps in services, and develop appropriate follow-up procedures. Clearly, interagency collaboration not only can help agencies meet their priorities and objectives but also can improve their services to clients.

In Chapter 3, a framework for collaborative efforts as well as guidelines and case illustrations are presented. In the discussion of ways to support collaborative efforts, such points as goals, needed resources and barriers are covered.

GOALS OF AGENCY COLLABORATION

State health, education and social service* agencies are united by similar goals: the delivery of specialized services to target populations. While they may define their target populations differently, they all seek to meet human service needs. In fact, these goals are so interrelated that often one agency, as part of its function, provides services related to another agency's functions. For example, schools provide counseling, health education and some health services; social service agencies are concerned with the health, education and employment needs of their clients; and health agencies want to assure that the populace is educated about the importance of physical and mental well being. Each agency's concerns and activities overlap in many areas. When dealing with an individual client, a variety of health, education and social services may be provided by one agency and referrals may be made to the other agencies. Thus, these agencies are affected by this interrelationship.

Webster defines "collaboration" as "cooperation with an agency or instrumentality with which one is not immediately connected." Cooperation is the key element in any such effort, focusing on areas of agreement and facilitating each other's efforts in the target areas. When collaborating, autonomous agencies develop and utilize mechanisms which effectively join them in the pursuit of a common goal. Each participating agency maintains its unique organizational structure, areas of expertise and points of intervention.

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* Other agencies also may participate in collaborative efforts on behalf of pregnant adolescents and adolescent parents. It is important that at least these three agencies work together on this effort.

Coordination should reduce the likelihood of duplicative efforts as well as provide a more comprehensive response to human service needs. Overlaps and gaps in service delivery may be identified and addressed. Other important advantages to collaboration are cost effectiveness and increased probability of funding. The likelihood that state legislatures, policymakers and community groups will be committed to the issue of teenage pregnancy and parenthood is greatly enhanced when major state and local agencies join efforts to meet the needs of these youth. Given an enlightened awareness of the issue, such groups become more likely to support and/or fund collaborative efforts in this field.

At the local level, the impact of state level cooperative efforts can be significant, leading to greater efficiency and consistency and less fragmentation at the program level. Conversely, local collaborative efforts can develop in the absence of guidance from the state. These efforts have been very successful and have often served as a model for state level cooperation.

In summary, collaborative efforts should produce greater consistency between policy and service delivery, greater efficiency by reducing duplicative efforts, improved services by identifying and eliminating gaps, and increased accessibility of services to clients.

ENCOURAGING COLLABORATION

Agencies must develop relationships with other agencies and organizations in order to exchange the resources--personnel, time and funding--needed to improve service delivery. Each agency involved in the effort must "buy into" the issue of teenage pregnancy/parenthood and accept its responsibility to that population.

The foundation for collaborative activities is the building of relationships among agency staff members. It is important that agency heads as well as staff at the appropriate programmatic levels be involved in the cooperative process. Staff from all the participating agencies need to recognize that such cooperation can be mutually beneficial. The leadership must make a commitment to the interagency efforts and the staff must work together to make collaboration a reality.

Differences in Agency Structure

Differences in agency structure must be taken into account when initiating an interagency policy development process. Health, education and social service agencies vary in their structural relationships to local counterparts. Some state agencies can set policies to which local counterparts must adhere; they can monitor the locals for compliance, provide training, and establish priorities. Although some state agencies have a line relationship with local counterparts, the areas of authority may be limited to specific issues that may not include adolescent pregnancy/parenthood. In contrast, other state agencies have less authority over and responsibility for their local counterparts. In some states, local agencies are autonomous, setting priorities and establishing procedures without the

state agency's involvement. Whenever staff from different state or local agencies work together on an issue, it is essential that they make clear to each other the parameters within which their agency functions. Such an understanding at the outset is invaluable throughout an interagency effort.

The Facilitator

The process of planning and formulating a collaborative effort can be greatly assisted by the selection of a chief planner/organizer, who is referred to here as a facilitator. The facilitator need not be an individual, but could be a task force or committee specifically organized to lead the interagency collaborative effort. Ideally, the facilitator is the individual who heads such a task force or committee. In this way, the leadership role and the administrative responsibility, while perhaps belonging to one individual, can actually be shared among committee members.

The facilitator must possess high levels of intuition, experience, political awareness, and luck. He/she also must understand the dynamics of working with independent agencies that are exchanging resources for the benefit of all and must have authority to initiate and stimulate action. In addition, the facilitator must have a strong commitment to the issue.

The importance of the facilitator cannot be overestimated. Therefore, a variety of factors must be taken into account when selecting this person. The facilitator should have the respect of the other people who are to be involved in the policy development effort. S/he should be competent, intelligent, personable and well organized. In addition to these qualities, the facilitator should be given appropriate authority along with the responsibility required for this effort, including the ability to call meetings and delegate responsibilities for suggested policy/program development.

The facilitator could be a "neutral" party, i.e., one who does not have a vested interest in which agency gets credit for the effort. Such neutral groups from which the facilitator could be chosen are the governor's staff, legislative committee staff, or an advocacy group. A benefit of this approach is that one agency is not seen as responsible for the effort while other agencies are viewed as ancillary; all are equally important. In addition such "neutral" parties may report directly to someone, e.g., the governor, who has authority over all the participating agencies and thereby can require their cooperation.

A "neutral" person, however, is not always available. Furthermore in some cases, one of the major agencies with responsibility for services to pregnant adolescents/adolescent parents already may have been designated as the facilitator. Whatever circumstances, the facilitator must be able to make the commitment necessary to function as the leader and must be accepted as the leader. The person selected to function as the facilitator also must have leadership skills and a commitment to work on this issue.

Committee Structure, Functions and Personnel

Many task force or committee structures are suitable for interagency collaborative efforts. A structure recommended by the Adolescent Parenthood Project Advisory Panel involves the establishment of a two-tiered committee, with policymakers forming one level, and staff forming the other. The staff portion of the committee is responsible for gathering data, analyzing it, and providing policymakers with information and recommendations. The policymakers, armed with these data, are responsible for planning policy directions and making policy decisions. Thus, each group plays a role appropriate to its area of responsibility. The two tiers of the committee meet separately and together as necessary to carry out their responsibilities.

Often a task force or group which is already functioning can serve as a governing committee. For example, the Teen Pregnancy Task Force in Oregon, composed of staff from a number of agencies as well as local program directors, is involved in information gathering and dissemination, and therefore would be very appropriate as a governing committee. Few states and communities have such task forces, however, and leadership is needed to bring them into existence.

The interagency committee should explore alternative courses of action based on present and potential policies and practices, develop options, and then select and implement appropriate ones. To provide a strong base for collaborative activities, a written statement by the interagency committee or agency head(s) is critical. Properly developed, it can guide the entire effort. First, it should state the purposes of the collaboration, as well as the need, objectives, target population, and focal areas. A plan of activity should be included. Second, the statement should describe the projected benefits to the participating groups. If it is not clear how each agency can benefit from collaborating, it will be difficult to get cooperation. This ingredient--the benefit to each participating agency--is part of the foundation to any successful collaboration and should be evident in the written statements as well as throughout the course of the collaborative activities. The value of such a written statement is two-fold: it provides direction to those participating in the effort and it serves as a resource to advocates.

It must be determined which agency or agency representatives will be ultimately responsible for maintaining the effort or if, in fact, the governing body should be accountable. The benefits of having one person or agency responsible for the effort are that communication and coordination are centralized and function more smoothly. The liability is that the responsibilities may be greater than one person or agency can or should manage. If the governing body is responsible, the duties may be divided more fairly, but the risk is increased that some will not fulfill their responsibilities appropriately and on time, thereby impeding the process. A careful assessment of the scope of the activities and the abilities of the members of the interagency body should be made before determining which approach will work best.

Other mechanisms to carry out the purposes of the collaborative effort should be established early in the process. Questions must be answered regarding the identification of issues, dissemination of information to participating agencies, sign off authority, and responsibility for initiating action.

Vital to the success of the effort is the ability of the persons involved to work together. The agency heads who appoint staff members to this committee should be aware of the interpersonal skills needed and should keep this factor in mind when making their selections. The selection of one person who is consistently negative, is difficult to get along with, and/or refuses to compromise can significantly alter the functioning of the entire committee. Care also should be taken to assure that people with a past history of animosity toward each other are not selected. Should such problems become apparent, the facilitator should take the necessary steps to reduce the conflict or, if that fails, replace the individuals who are impeding the efforts of the group.

Once the agency representatives have been selected, they must all participate in the work of the committee. Without dedication and commitment by a cadre of people who actually will do the work, the collaborative effort will remain a philosophical exercise. A detailed work plan must be developed and the tasks specified and distributed. A system for feedback that informs other members of the status of these tasks must be set up, and in some cases, minutes of meetings can serve this purpose. The key word here is system--for assigning work, getting it done, and reporting on it. Without a system, work will be done haphazardly and sporadically.

MANAGEMENT ISSUES

The tasks of this interagency effort will involve: (1) goal setting; (2) allocation of resources, including personnel and funding; (3) management of the endeavor, including planning, coordination, research, data collection and evaluation; (4) information (5) interagency agreements covering referral processes, services fees, and accountability; and at the service provider level, (6) case management/coordination/followup. A written statement, as described earlier, already may address several of these activities. However, if no such guidance has been provided, or if all these items have not been detailed, attention should be turned to them. Each is described in more detail below.

GOAL SETTING

Once a collaborative effort is initiated, the first task is to establish measurable and realistic goals. Reasonable goals for state efforts include implementing state agency policies which facilitate the delivery of services and establishing programs at the local level. Measurable results of local collaborative efforts might include a reduction in the number of teen pregnancies, reduction in the number of low birthweight babies born to teens, and/or completion of high school. Such results are reasonable indicators of success and, as such, encourage the collaborative effort to continue and expand. Publicity about such successes informs the community as well as state policymakers and strengthens support for collaboration.

ALLOCATING RESOURCES

The two resources to be allocated are personnel and funds. With regard to the former, an agency cannot participate in a collaborative effort without assigning staff to meet this responsibility. To enable this person(s) to function effectively, he/she must be given time to work on this effort. The staff person also needs the interagency authority to request and receive information from other units on their activities, to request their involvement as needed, and to have access to the decision-makers. It is not necessary to hire new personnel to meet the staff requirement. Changing a staff member's priorities, expanding the time staff spend on the issue, or reassigning duties can usually provide the time necessary.

The staff member selected should be someone who works well with people and who has knowledge of many of the agency units responsible for the target population. This person should be knowledgeable about the agency and its mission, goals, priorities, programs, and resources. He/she should be able to propose tentative areas for cooperative activities. Last but not least, the staff member selected should be committed to working on behalf of the target population and believe that interagency collaboration can enhance the agency's efforts.

FUNDING

When considering fundraising approaches, financial support for endeavors in this field may be available from federal agencies and, quite possibly, from foundation or corporate grants or state allocations. Avenues of funding should be explored by the interagency body or whomever they designate to identify fundraising possibilities.

Whether or not a special fund needs to be developed for the activities undertaken through the collaborative effort will vary and should be determined by those participating in the process. In some cases, the agencies themselves may contribute financially to the effort. If the collaborating agencies decide to develop a fund or transfer funds to support this activity, there should be a clear, written agreement specifying the amount to be allocated by each agency and the purposes(s) for which the funds are to be used. Authority for administering the money should also be established.

MANAGING COLLABORATION

To establish accountability within the collaborative effort, it is critical to determine which agency(ies) and which staff members will be responsible for the planning, research, data collection and evaluation. These activities are vital to document the need for and effectiveness of the endeavor and may require a considerable investment of time. Staff should be assigned specific responsibilities and given the authority needed to accomplish their tasks.

It is also essential to develop a master plan for coordinating all the activities. A timetable for the estimated completion of all tasks should be developed and used as a tool for guidance and monitoring. It may be appropriate to develop a flow chart outlining how the tasks and activities mesh.

INFORMATION DISSEMINATION

The collaborative process should include a mechanism for informing people within and outside of the agencies about the focus of the activities and the progress that is being made. While this need has already been discussed in relationship to communication with agency heads, it is important to remember that others who are concerned about the issue also need to be informed. Advocates need to know what is happening, how proposed changes might influence their efforts, and what is planned for the future. Opportunity for feedback should be provided as well. Keeping others informed about the committee's efforts demonstrates that progress is being made, and provides an opportunity for others to make an early contribution to the development of ideas, thereby strengthening the entire effort.

INTERAGENCY AGREEMENTS

A crucial area for consideration and thoughtful planning is that of interagency agreements. These may cover staffing, referral processes, finances and/or accountability. Any subject which can best be dealt with over the long term by the development of a written agreement should receive consideration.

Written agreements strengthen the collaborative process in several ways. First, they specify what is expected of the parties involved. This is particularly helpful in fostering continuity when personnel change. Second, they clarify the responsibilities of the participating entities. Third, in the process of developing the interagency agreement, agencies may discover that they have resources not previously identified which can contribute to the effort.

The content of interagency agreements will vary based on the goals of the agreement, the agencies participating, and the activities being undertaken. Agreements should, however, cover at least the following items:

- the purpose of the agreement;
- the agencies that are participating, including the appropriate subdivisions which will be involved;
- the activities being undertaken, including a suggested timeframe for completion;
- the individual(s) responsible for administering the agreement and seeing that the activities are completed in a timely and appropriate manner;
- any exchange of money, including reimbursement procedures; and
- amount of staff time each agency will devote to this effort.

Two examples of existing written agreements (one state-level and one program level) directed toward pregnant adolescents/adolescent parents are included in Appendix B.

Some liabilities are associated with the development of written agreements. First, the parties may get diverted from the project goals by the minutiae of a proposed agreement and never reach consensus. Second, some agencies may have more latitude to act without a written agreement. Finally, written agreements may place constraints on additional activities that may be proposed in the future. Thus, the development of written agreements should be approached carefully, with an understanding of what is proposed and expected by all the parties involved as well as the probable benefits and liabilities of this approach.

CASE MANAGEMENT/COORDINATION/FOLLOW-UP

At the local level, when discussing the actual provision of services through an interagency effort, a system specifying who has responsibility for case management, coordination, and follow-up is needed. For example, it would be duplication of effort if each agency had the duty of total case management. Instead, the responsibility should be divided among agencies or assigned to specific staff. A truly coordinated approach to integrated services would feature centralized case management and follow-up as well as a referral system. This centralization necessitates a carefully delineated plan for cooperation among the participating agencies.

BARRIERS TO COLLABORATIVE EFFORTS

A number of barriers to collaborative efforts deserve explicit mention. Many can be addressed or circumvented by following the process described in this chapter; others will have to be handled as they arise. When agencies pursue different goals or pursue similar goals through different means, tension often develops. Such conflicts can be managed effectively, however, and should be seen as part of the evolution of the collaborative effort.

One of the major barriers to collaboration is the failure to establish clear responsibility and authority. If no one has lead responsibility for the effort and/or the individuals who are participating do not have the authority to represent their agency, little progress will be made.

Each agency head should designate appropriate staff, their responsibilities, and the necessary lines of authority so that agency personnel will understand the roles they are to play. In addition, the participating agency heads should determine who has lead responsibility for the focus and functioning of the entire effort.

Another barrier is lack of trust among the participants. Interpersonal problems are one of the biggest roadblocks to collaboration. Some steps in preventing these problems have been described: selection of people with good interpersonal skills and efforts by the facilitator, agency head and others to work with persons who exacerbate problems and/or to replace them. If an obstructionist cannot be persuaded to become a team player and cannot be replaced, efforts should be made to work around the obstacles he/she presents. Over time, trust and a commitment to collaborating may overcome or lessen the problems this person presents.

Problems will arise if understanding of the mission, structure and functioning of the different agencies is inadequate or if staff from one agency have misconceptions about why each agency is participating. When the cooperative efforts are beginning, it is advisable to spend considerable time sharing background information on the history of each agency's involvement in this area, its current activities, how each agency functions and what procedures will govern its participation in the collaborative effort. While this process is time consuming, its value in preventing problems will be well worth the investment.

Any changes in agency priorities or leadership can threaten the cooperative process. When new priorities are established, there should be an immediate effort to relate them to the current focus and to the advantages of interagency collaboration. Informing a new leader(s) of the relevance of adolescent pregnancy and parenthood to other areas with which he/she is concerned is essential, as is documenting how the collaborative effort is benefiting the agency in terms of cost savings, improved methods for meeting its mission and favorable community response.

Money, time and resources are additional barriers to collaboration. While money can help overcome time and resource deficits, other sources for assistance should be sought while funds are being raised. In addition to contributions from the participating agencies, it may be possible to get help from advocacy groups, colleges and universities, and other agencies. Flexibility and ingenuity are essential assets, especially when seeking the needed resources.

Perhaps the most common pitfall is the failure to document the impact of these efforts on the participating agencies, their activities, and on the clients they are seeking to serve. It is of paramount importance to maintain a record, beginning with the state of each individual agency's efforts before the coordination activities began, how each agency's activities have evolved throughout the process, and the current status of the effort. Whenever possible, data on the collaborative activities should be collected, documenting their impact on service delivery, duplicative efforts, and cost effectiveness. With such a record, it is possible to ascertain what the collaborative effort has contributed to the individual agencies as well as to their clients. When continuation of the effort is questioned, an accurate assessment is possible and an informed decision can be made.

The committee should expect barriers to emerge through the entire process and should take these in stride. While obstacles can be frustrating, overcoming them is an intrinsic and rewarding part of the process and clearly demonstrates the progress that has been made. Because each collaborative effort is unique, ingenuity and determination will be critical to success.

CASE ILLUSTRATIONS

To provide concrete examples of the process of collaboration, six illustrations of how such efforts actually worked, three at the community level and three at the state level, are presented. With an understanding that it is possible to learn from failures as well as from successes, examples of both are provided.

COLLABORATIVE COMMUNITY EFFORTS

St. Paul-Ramsey Maternal and Infant Care Project

At the program level, one project that has been very successful in improving and coordinating a number of services to its clients is the St. Paul-Ramsey Maternal and Infant Care (MIC) Project. This program, which began in 1973, provides a variety of health and child care services to students in two local high schools. Since the inception of the program, deliveries among the students have declined by 40 percent and fertility by 23 percent (Edwards et al., 1980). Achieving this success took much time and effort.

Planning and implementing the program took almost two years. The proposal was to provide family planning and prenatal care services through an experimental health facility located within a school. The school superintendent gave his approval to pursue the concept; meetings were held with the regional MIC staff, a joint school-hospital-city health department administrative group, and special committees to study the plan.

Throughout the development process, these special committees reviewed the suggested plans and recommended changes. During the development of the plan, three presentations were made to the local school board. Much time was spent responding to the concerns and objections raised by individuals and groups and making necessary accommodations. For example, it was decided that family planning information and counseling, and physical examinations could be provided in the school but birth control methods could not be dispensed. Instead, health clinics, often near the school, would provide this service. After many other accommodations were made, the project was approved for a one-year period, to be evaluated at the end of that time.

The first health clinic office was located in a former storage room; many interested students did not come to the clinic because they were concerned that people would know they were sexually active. Recognizing this problem, the clinic's staff expanded the program to respond to other needs and began providing athletic, job and college physicals, immunizations, and a weight reduction program. With these changes, a move to a better location, and a reduction in mistrust as the faculty and students became acquainted with the clinic personnel, the project reached many more students, including those concerned about fertility issues. The program was approved for continuation.

There are several points that the staff believe were very important in the development and approval of this project. First, they were patient with the time-consuming process, recognizing that people needed to become familiar with the issue, have time to review the plan, and get responses to their concerns. Second, they were willing to adapt their ideas to meet the oojections and needs of the participating agencies. Third, citizens who opposed the project were placed on the study committees to make certain that their views were heard. As they became more familiar with the needs, proposed project activities and staff, their objections dissipated. Fourth, the staff tried to reassure the school and medical staffs involved by not threatening them or their turf. Patience, persistence and politeness were required throughout the development phase.

Since the implementation of the program, the project staff have measured their effectiveness, reported their findings to all of the agencies involved and enlisted support for continued and expanded efforts. Frequent and positive communication has facilitated and sustained support at all levels for this project.

Austin Schools and Child Care Centers

An interesting collaborative effort which joined public and private sectors began in Austin, Texas in 1976. The home economics superevisor for the Austin Independent School District wrote a grant to provide infant and child care services for the children of adolescent parents so the parents could remain in school and get vocational training. As proposed, the school system would contribute staff for the child care centers and a private, nonprofit child care organization (Child, Inc.) would contribute space. The program was funded through Title IV-C of the Elementary and Secondary Education Act which appropriated monies for innovative efforts in local school districts.

The program provides child care for the children of students in the Austin Independent School District who are usually involved in the center daily and are enrolled in a vocational program. Other students in the school often use the child care center in conjunction with such courses as child development and psychology.

Although the project was carefully designed for the grant proposal, some impediments were not recognized initially. The most important were certain restrictions of the funding agents. This problem was resolved by completely reversing the responsibilities of the two participating agencies: the child care organization decided to provide the personnel and the school district agreed to provide the space. From the outset, flexibility and creative solutions have been intrinsic to the success of this collaborative program.

Program personnel cite staff commitment in both agencies as the most important ingredient in their success. Since obtaining the initial Title IV-C seed funds, the staff were able to elicit funding from Title XX and the city. Because program personnel were able to establish trust among

themselves, minor difficulties were resolved. In fact, the person employed by the school district was given responsibility not only for the portion managed by the school district but also was designated by the head of the child care organization to oversee that portion of the program. As a result, she is able to coordinate all aspects of the program with a minimum of turf problems. Finally, the program personnel have established credibility within their own agencies as competent, knowledgeable people.

Like the state collaborative effort in Michigan, this program has faced difficulty with fiscal agents who are not committed to the value of the program but who are interested in having a standard accounting procedure. This goal has been particularly difficult to reach because two distinct agencies are involved. Throughout the life of the program these two agencies have had different fiscal years, reporting requirements, policies, and procedures not only for themselves but also with their funding agents! These disparities have been overcome through flexibility, creativity and perseverance.

Fortunately, personnel involved on several levels had a strong commitment to the program that motivated them to find ways to overcome the barriers. Because the person managing the program for the school district is several lines down in the administration, a committed, highly-placed school official has been very instrumental in protecting and promoting the program. While some people have criticized the program as being too costly, the personnel have been careful to document its impact. Because they have been successful in keeping adolescent mothers in school and in reducing the incidence of a subsequent pregnancy, they have been able to promote the cost-effectiveness of the program. Because they made the child care centers open to all students as laboratory experiences, they have expanded the number of students served, thereby expanding the support base for the program. Competent and committed staff, diversified funding, the laboratory center approach, documented results and creativity have been key elements in the success of this program.

A City-Level Collaborative Effort that Failed*

An initiative begun at the city level in the late 1970s involved twelve agencies that agreed to study the implementation of existing local policies regarding teenage sexuality and pregnancy. As part of this effort, the group decided to publish a newsletter, a project that increased visibility and eventually led to the expansion of the group to about 35 representatives from organizations and agencies concerned about these youth. The group developed recommendations for improving services to pregnant adolescents/ adolescent parents and then began actually providing outreach services, primarily education and counseling, in neighborhoods throughout the city.

Eventually the group identified potential sources of funding for current and expanded activities. To insure local support, they sought and received the endorsement of community leaders. Given the number of collaborating groups, one of the key tasks was determining which should be the primary grant recepient. This decision was made by city officials, and the other groups agreed to participate in the proposed project.

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* Unsuccessful efforts will remain anonymous.

Unfortunately, changes occurred in the administration of some of the involved agencies, concomitant with the substantial tightening of city expenditures. The new city focus on cost cutting made acquisition of funds from outside sources even more important.

The organizers met with the funding sources during the process of proposal development, but did not feel encouraged in their efforts although they were told to apply. Rumors circulated that another group had political connections and would be awarded the funds. When contacted by this group and invited to apply as part of their proposed plan, the interagency group declined because they felt that their own proposal was much stronger. When, in fact, the other group did receive an award, the people participating in the collaborative effort felt that they had been misled. One of the participants stated that it was not the fact that they had not received the grant that mattered the most; it was the belief that they had not been given fair consideration. They suffered from "burn-out." Although there was some regrouping, the collaborative efforts have, for all intents and purposes, stopped.

When asked what could have been done differently, a representative from the group made several suggestions. First, when seeking funding it is critical that there is a good match between the priorities of the funding source and the group applying for assistance. Second, the applicant group also should assess the political realities regarding who is likely to be funded. If, for some reason, there is a group that seems to have the inside track, careful consideration should be given to participating with this group rather than applying separately. Third, alternative plans should be developed so that if the funding does not become available, other activities will maintain group collaboration.

Unfortunately, in this case a combination of factors--city budget cuts, a focus on acquiring funds, and a perception that politics, rather than merit, was the basis for funding--led to the demise of this collaborative effort.

COLLABORATIVE STATE EFFORTS

Michigan Interagency Committee

A successful state policymaking effort focusing on adolescent pregnancy and parenthood began in Michigan in 1975. Dr. John Porter, head of the Department of Education, sought and received support for addressing this issue from the heads of the Departments of Public Health, Mental Health and Social Services. An interagency committee was formed, involving representatives from these departments and, later, from the Department of Management and Budget. One major purpose of the interagency committee was to develop a comprehensive model for school-based programs for pregnant adolescents and adolescent parents.

Prior to this effort, over 60 school-based programs for pregnant adolescents were receiving funding for teachers' salaries ($900,000) from the Department of Education. Because these programs evolved at the local level, they varied in services and organization. The interagency committee encouraged their efforts and provided guidance to help them enlist additional support, develop better organization, and expand to provide more comprehensive services. This state level support provided evidence of the importance of such programs to personnel at the local level.

In 1977, the interagency committee applied for and received a grant from the Administration for Children, Youth and Families in the U.S. Department of Health, Education and Welfare. These funds, provided for three years and administered by the Michigan Department of Public Health, were used by the interagency committee to hire two full-time staff and a secretary, who were responsible for preparing information, coordinating activities and assisting the committee.

As part of the collaborative effort, the committee sought and received the governor's support for additional state funding for pregnant adolescent programs. Committee members and staff educated the legislators and personnel in the state Office of Management and Budget about the need for and purposes of this money, and the state legislature appropriated $240,000 in 1979. This money was in addition to the $900,000 already provided and was earmarked for comprehensive services for pregnant adolescents/adolescent parents and their children. The Department of Education, as the agency administering the funds, then asked for proposals from local education agencies which wanted to develop or expand their programs. Three were selected and received funding for the 1979-80 school year.

The major accomplishments of this effort included the development of a model for comprehensive school-based programs for pregnant adolescents and adolescent parents, increased recognition throughout Michigan of the needs of this population, and the development of a good working relationship among the participating agencies at the state and local levels.

Personnel involved in this effort cited several factors which contributed to their success. First, Dr. Porter assumed responsibility for this effort through the Department of Education. He was able to enlist the strong support of the directors of other agencies because they had confidence in him. Second, the purpose of the interagency committee--developing a model for comprehensive school-based programs for pregnant adolescents/adolescent parents--was very focused, which made its mission clear and diminished the development of turf struggles. Third, the rapport among the committee members was very good. Fourth, the committee was an executive agency group, advisory to the participating state departments. Public input was obtained from the School-Age Parent Task Force, an advocacy group in Michigan which served as an advisory group to the state interagency committee. Fifth, the committee was able to obtain money. Leadership, a clear purpose and structure, a good working relationship among the participants and funding assured the success of this effort.

Nevertheless, several problems developed during the collaborative process. Sometimes the state agency representatives who were several layers down in the bureaucracy did not have a direct channel of communication to the head of the agency. Conversely, some who did have direct access encountered occasional problems when they bypassed their immediate supervisors. Eventually these problems were worked out, but time and energy could have been saved if the lines of communication had been established clearly at the outset. Generally, it is best if there is some mechanism for direct reporting to the agency head as well as to the immediate supervisor.

Another problem was the turnover in agency personnel who participated on the committee. To overcome discontinuity, the interagency staff oriented new members on the history and purpose of the committee and minutes of their meetings were used to inform newcomers, as well as members who had missed a meeting. A third problem developed related to managing funds. Because the interagency committee itself was not able to apply for funds when the budget proposal for services to pregnant adolescents was developed, it was agreed that the Department of Education would administer any grants. However, the interagency committee, in developing its model of services and funding, did not involve the Department of Education's finance section early in this effort. Considerable time and energy had to be invested later to establish appropriate procedures for administering the grants.

While these problems did not prevent the development of the collaborative process, they slowed its progress. Despite such drawbacks, Michigan has been very successful in implementing an interagency collaborative effort at the state level.

New York State Efforts

A particularly interesting collaborative effort began in New York at the state level in the early 1970s. The state Department of Health approached the Department of Education to discuss the increasing rates of pregnancy among school-age girls. An ad hoc interagency committee on adolescent pregnancy was formed involving these departments as well as the Department of Social Services and the Division of Youth Services. Along with other agencies, they reviewed the statewide policies and objectives and proposed specific actions to address the needs of pregnant adolescents in a coordinated manner. As part of this effort they also held information seminars for the general public in communities across the state.

In January, 1978, Governor Hugh L. Carey in his State of the State address directed the Department of Social Services, in conjunction with other state agencies, to ensure that adequate family planning services be provided to teenagers who are either pregnant or young mothers. The Department of Social Services established a task force of experts from outside the government and developed a report describing the extent of adolescent pregnancy in the state, resources available to address these needs, and recommendations for action. Between 1978 and 1980, the Governor requested and the legislature appropriated $2,750,000 specifically to address the needs of pregnant adolescents/adolescent parents. Through a competitive proposal process the Department of Social Services has used this money to fund 22 projects providing preventive and supportive services to pregnant adolescents and adolescent parents.

In addition to these efforts, the Departments of Health and Education have also targeted services to these youth. State funds for family planning programs under the Department of Health increased by 160% between 1976 and 1978, with a major portion devoted to services to teens, a statewide multimedia campaign, and educational services for adolescent parents. The Department has supported two projects in New York City for outreach and post partum services for adolescents and one project in Buffalo for capital improvement in a teen center. In addition to these activities New York was selected in FY 79 to receive an Improved Pregnancy Outcome grant from the Bureau of Community Health Services in the U.S. Department of Health, Education and Welfare.

These efforts demonstrate not only how the state can improve coordination of its own policies and services but also how each department can improve coordination from the state to the local level. Particularly noteworthy in this respect are the activities of the New York State Department of Education in helping local school districts to plan and implement programs in the following areas: (1) K-12 family life/human sexuality education; (2) family life/human sexuality education for parents; (3) parenting education (both K-12 and parents); and/or (4) educational programs for school-age parents who are either pregnant, prospective fathers or parents.

By the end of 1980, 34 school districts, six Boards of Cooperative Educational Services (BOCES), seven community school districts in New York City and one high school in New York City had been involved in the program. These programs have involved over 1,000 parents and 800 teachers in parent education, curriculum development, classroom teaching and/or advisory committees. Educational policies for pregnant girls, prospective fathers and student parents are being clarified. Case management procedures and interagency cooperation have been stressed to facilitate the provision of services to these adolescents. Over 70,000 students have been reached through one or more of these programs. The local programs have established direct ties with over 100 agencies and indirect ties with an additional 80 agencies across the state. There is a waiting list for more than 30 districts to receive the technical assistance and funds provided through this project from the state Department of Education.

The state departments in New York improved the delivery of services to pregnant adolescents/adolescent parents by providing technical assistance and financial incentives to their local counterparts. Often the technical assistance has included guidance on how to establish ties with other service organizations concerned with these adolescents.

There are several factors that have fostered interagency cooperation in New York State. First, the key people in the departments of Health, Education and Social Services recognized the need to work together. Second, the governor and the department heads agreed that a joint effort should be undertaken and that money should be appropriated to facilitate collaboration. Third, they documented the need for services and the impact of adolescent pregnancy on the families involved as well as on the state. Fourth, people in the state agencies made a strong commitment to work with their local counterparts to improve the delivery of services. They also promoted public awareness and elicited support for programs and services.

They established a climate among policymakers and the public on the importance of addressing the needs of these adolescents. In turn, this support has enabled them to target funds to provide and coordinate services.

These interagency efforts to collaborate, like other efforts, have encountered certain obstacles. Originally, state level policies and services for pregnant adolescents and adolescent parents were not linked across agencies. To overcome this gap in communication, an interagency coordinating committee was established. Its main task was to develop a proposal for submission to the Office of Adolescent Pregnancy Programs, to select projects for state funding and to provide technical assistance to programs serving this population. While the monthly meeting by the committee has increased communication significantly, bureaucratic and philosophical struggles (allocation of funds, prevention and education vs. services, and the responsibilities of the respective departments) have not been entirely overcome. The three agencies did draft a planning proposal to submit to OAAP to enhance collaboration, but after they discussed their plan with the head of that office they decided not to apply. The Department of Health, however, submitted a plan for services and received funding; the Departments of Education and Social Services are linked tangentially to this effort.

Failure of One Collaborative Attempt

Another collaborative effort at the policymaking level was not successful in getting the agencies to cooperate. The purpose of the collaboration was to bring administrators from a diversity of agencies together to coordinate efforts in program planning, service delivery, and technical assistance. Participants noted several barriers that effectively scuttled this effort. First, there was a lack of central leadership commitment. Unlike Michigan, the directors of the agencies did not explicitly state their support and did not direct their staff to cooperate. Although there was a mandate for coordination, the lack of commitment by the agency heads created a variety of problems. To protect their own turf, people were unwilling to share information or resources. Some agencies had many representatives while others had only one. This imbalance immediately placed a disproportionate emphasis on some and gave others the impression that their contribution was ancillary.

Another problem was that the benefits to the participating agencies were obscure. Being unaware of what their agencies could gain, personnel were less willing to share resources or make a commitment to the effort. Finally, there was no plan outlining how the group was to function, what the objectives of collaboration were to be, or the proposed outcomes. Those charged with leadership were unable to build trust and confidence in their abilities or in the collaborative effort. The lack of effective leadership at the agency head and facilitator levels led to the demise of this collaborative attempt.

These cases are provided not only to illustrate the challenge of collaboration but also to guide other efforts. While coordination requires considerable time and skill, an interagency approach can make a dramatic impact on the quality and comprehensiveness of policies and services to clients.

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APPENDICES

APPENDIX A

EXISTING PROGRAMS FOR PREGNANT ADOLESCENTS AND ADOLESCENT PARENTS

PURPOSE OF THE STUDY

NASBE conducted a survey of existing adolescent pregnancy and parenthood programs in 1980. The design for this study provided for a comparison of two groups of programs, which are identified in this report as "exemplary" and "non-exemplary." Because the major emphasis of the Adolescent Parenthood Project has been to examine state agency policies and programs serving adolescents who were pregnant or parents, the directors of each state's health, education, and social service agency were contacted and asked to nominate up to three (3) "exemplary" adolescent pregnancy and parenthood programs in their state. In the U.S. Department of Health and Human Services, the Office of Adolescent Pregnancy Programs (OAPP) also was asked to make nominations.

Nominations were received for 169 different exemplary programs from the state directors and OAPP. Telephone contact then was made with a selected group of the directors, asking them to specify criteria they considered important when they identified exemplary programs. Their comments, as well as a list of characteristics developed by the NASBE staff, became the point of reference for drafting and revising the survey questions. The questionnaire was then pilot tested within the greater Washington, D.C. metropolitan area. The responses obtained led to further refinements in the questionnaire and the final survey instrument was distributed to the selected projects in March, 1980.

To identify programs not mentioned as exemplary, two directories were used: the National Directory of Services for School-Age Parents, published by the National Alliance Concerned with School-Age Parents (1976) and Child Rearing Programs for School-Age Parents: A Resource Guide, developed by the National Institute of Mental Health (1979). Thus, programs in the "non-exemplary" group may be excellent programs; their designation indicates only that they were not nominated by state agency personnel.

Questionnaires were distributed to a total of 169 exemplary programs and 326 non-exemplary programs. A total of 81 returns (48% response rate) was received from exemplary programs and 124 (38% response rate) from non-exemplary programs.

The data provided by the respondents on the mailed questionnaire have been grouped into the following categories:

- Program History
- Program Administration
- Demographic Characteristics of Programs
- Funding Characteristics
- Services Provided to Client Groups (see Chapter 1)
- Evaluative Activities of Programs

On the whole the two groups were remarkably similar. Analysis of the data revealed substantial differences between exemplary and non-exemplary programs in only a few categories: agency base, amount of outreach provided or received, and extended family members served. There are a number of possible reasons why there were not more differences between them: 1) no other differences existed; 2) the questionnaire failed to capture other differences; or 3) the procedure for identifying these two groups was not valid.

PROGRAM HISTORY

Four questionnaire items relating to the history of the programs were examined. Almost 70 percent of those returning questionnaires indicated that their program had been initiated prior to 1973. Additionally, about 90 percent of the respondents indicated that the agency responsible for administering the program at the time of the survey and the agency which administered the program at its inception were the same. Table 1 breaks down the responding agencies into public and private categories as well as the type of agency which currently administers the program.

Because the NASBE Adolescent Parenthood Project is studying policies as well as services, the respondents were asked to rate the importance of policy set at different levels. Table 2 presents the percentage of those responding to this item who thought policy had a substantial impact at each of the potential policymaking levels. The municipal and county levels are ranked low by both groups. Policy set at the program level was rated most important, followed by local, state and federal levels. The exemplary programs, however, rated federal policies as much more important than did the respondents from non-exemplary programs, perhaps because they are more likely to receive federal funds (see "Funding Characteristics").

PROGRAM ADMINISTRATION

In the exemplary group, the administrative breakdown of the responding agencies is 48 percent education-based, 17 percent social service-based, 25 percent health-based and 10 percent a combination/other. The breakdown in the non-exemplary programs is 71 percent education-based, 19 percent social service-based, 5 percent health-based, and 5 percent a combination/other.

Table 1
Administrative Characteristics of
Respondent Programs

	Exemplary N=81	Non-Exemplary N=124
Year in Which Program Was Initiated		
Prior to 1973	60.9%	73.1%
1973 to 1975	3.4	7.6
1975 to 1977	14.9	7.5
1977 to 1979	13.8	7.6
1979 to Present	6.9	4.2
Status of Program		
Public	73.0%	76.5%
Private	27.0	23.5
Administering Agency		
Health	24.7%	5.0%
Education	48.1	70.6
Social Service	17.3	19.3
Other or Combination	9.9	5.0

Table 2
Respondents Ranking Policy Impact as "Substantial"

	Exemplary N=81	Non-Exemplary N=124
Policymaking Level		
Federal	25.9%	12.1%
County	13.6	16.1
Program	69.1	62.9
State	38.3	29.8
Municipal	8.6	6.5
Local	30.9	40.3

The dominance of education agencies in both groups and the small number of health programs in the non-exemplary category should be kept in mind whenever the two groups are compared. Education may be heavily represented because the majority of programs for pregnant adolescents/adolescent parents were education-based, according to the 1976 NACSAP Directory. There is a more equitable balance among the types of agencies in the exemplary category probably because the nomination process involved representatives from all three types of state agencies.

The majority of programs (N=115) provide their services at one site, yet a substantial number (71) have two or more sites. Two questions were asked about the amount of days spent providing or receiving outreach services. Outreach was defined as having staff from one program go to another agency to provide services without charge. Table 3 shows that 46 percent of the exemplary and 31 percent of the non-exemplary programs provided outreach services. An even more striking difference is the estimated number of days donated by those who do provide outreach services: 128 by exemplary versus 60 by non-exemplary programs. While a higher percentage of non-exemplary programs (64%) received outreach services than did exemplary programs (56%), the number of days received is substantially greater in the exemplary programs (67 days vs. 43 days).

There are a number of possible explanations for these differences between exemplary and non-exemplary programs. Staff of the exemplary programs may establish more ties with other agencies, and thus donate and receive more outreach services. Exemplary programs may provide a greater diversity of services and thus may involve more service providers. Perhaps exemplary programs are considered "exemplary" because they are more involved in outreach activities, which, ultimately, may cause them to be better known within their states. Whatever the reasons for this difference, exemplary programs were much more involved in outreach services than non-exemplary programs.

Table 3
Outreach Services

Outreach	Exemplary % N=81	Non-Exemplary % N=124
PROVIDED Outreach Services	46% (37)	31% (38)
RECEIVED Outreach Services	56% (45)	64% (79)
Average Number of Person Days PROVIDED	67	43
Average No. of Person Days RECEIVED Last Year	128	60

To learn more about internal administrative practices, information on several program characteristics was requested. Table 4 presents a summary of these data. The respondents were asked to report the number of professionals in different fields who were providing services to pregnant adolescents/adolescent parents through their project. Programs generally had staff from several, but not all, of these areas. Among the exemplary group, programs had an average of 3.6 nurses, 2.7 social workers, 2.7 teachers, 2.7 paraprofessionals and 2.2 volunteers. All other categories had an average of less than 1.5 persons. Among the non-exemplary group the programs had an average of 3.7 teachers and 1.7 paraprofessionals. All other categories had an average of less than 1.5 persons.

The high number of nurses involved in exemplary programs may result from the higher proportion of health-based programs in the exemplary category. In comparing the two groups, it is important to note that there is a higher average number of nurses, paraprofessionals, social workers, and volunteers involved in exemplary programs while there are substantially more teachers and somewhat more counselors in the non-exemplary group. These differences reflect, in part, the different proportions in the agency

Table 4
Average Number of Staff Providing Services

Staffing (By Function)	Exemplary N=81	Non-Exemplary N=124
Administrators	1.0	1.0
Counselors	0.6	1.0
Nurses	3.6	1.3
Paraprofessionals	2.7	1.7
Physicians	0.6	0.4
Psychologists	0.2	0.3
Social Workers	2.7	1.1
Teachers	2.7	3.7
Volunteers	2.2	1.4
Staffing (By Status)		
Professional, Full-Time Employees	5.8	5.8
Professional, Part-Time Employees	3.0	3.2
Clerical or Secretarial, Full-Time	2.0	1.8
Clerical or Secretarial, Part-Time	1.2	3.0
Other Paid Staff	3.9	5.7
TOTAL	15.9	19.5

base of the two groups. What is important is that the average number of full-time staff in exemplary programs (11.7) is lower than that in the non-exemplary programs (13.3). This difference is surprising given that exemplary programs serve 26 percent more family members (see "Demographic Characteristics"). From this survey it is not possible to determine the basis for this disparity.

Five questionnaire items requested information about the degree to which volunteers were involved in the programs. The use of regularly scheduled volunteers was reported to be high, with each volunteer averaging almost four hours per week. Surprisingly, few programs (N=18) reported the use of volunteers in advocacy activities, with a greater number of program respondents indicating that volunteers were used in health care (N=48), child care (48), teaching (42), and counseling (37) activities. There were no substantial differences between the exemplary and non-exemplary groups.

Table 5 gives the average number of hours reported for in-service training in the given subject areas. In general, about 40 percent of the exemplary programs and almost 30 percent of the non-exemplary programs provided in-service training for the staff/volunteers in the previous year. It is noteworthy that the non-exemplary program respondents reported a higher average number of hours spent in in-service training in four of the six categories. It may be that, in general, schools offer more in-service training and their higher representation in the non-exemplary category accounts for this difference.

Table 5
Hours of Inservice Training Conducted in 1978

Subject Areas	Exemplary	Non-Exemplary
Adolescent development (physical and psychosocial)	14.0	17.6
Child development	13.5	13.7
Health aspects of pregnancy and delivery	10.2	17.7
Life coping skills	12.7	11.1
Parenthood during adolescence	12.5	12.9
Referral services available to program participants	10.7	9.9

DEMOGRAPHIC CHARACTERISTICS OF PROGRAMS

To better understand the programs selected for inclusion in the survey, information of a demographic nature was sought. It was hypothesized that, in order to be representative, the sample utilized in this study should include urban, suburban and rural programs. Table 6 summarizes the geographic areas represented by the programs and shows that programs representing all these areas are included in the sample.

Table 6
Geographic Areas Served

Areas Served	Exemplary N=72	Non-Exemplary N=116
City	34.7%	34.5%
Suburban Community	4.2	12.9
County	30.6	17.2
Rural Area	12.5	12.9
Other (combination of above)	18.1	22.4

Table 7 presents a summary of the number and types of clients served. Non-exemplary programs served a slightly higher number of teenage women who are pregnant or mothers (230 v. 219), while exemplary programs served more fathers, grandparents, siblings and other family members. When the total number of clients in all these categories are tallied, the exemplary programs served an average of 273 persons involved in a teenage pregnancy other than the adolescent herself while the non-exemplary programs served an average of 157 such individuals. Thus, it seems that on the whole these exemplary programs placed more emphasis on involving family members.

Table 7
Average Number of Clients Served by Program Type

Clients	Exemplary	Non-Exemplary
Pregnant adolescents/adolescent mothers	219 (66)*	230 (114)
Fathers	30 (45)	26 (53)
Parents of pregnant adolescents/adolescent parents	145 (33)	91 (47)
Siblings of pregnant adolescents/adolescent parents	46 (22)	18 (26)
Other family members	52 (18)	22 (22)
Total	492	387

* The number in parenthesis indicates the total number of programs providing a response for this item.

FUNDING CHARACTERISTICS

Recognizing that the scope of services available to clients--as well as the number of clients served--is largely dependent upon funding, four questionnaire items surveyed the type and source of funds received by the programs. Table 8 shows that the programs surveyed were distributed across all budget categories with the greatest percentage reported in the "Less than $50,000" category.

Table 8
Program Funding Items

Total Budget for Program in FY 1978	Exemplary %	Exemplary N	Non-Exemplary %	Non-Exemplary N
Less than $ 50,000	40.4	(21)	43.2	(35)
$ 50,001 to $100,000	21.2	(11)	21.0	(17)
$100,001 to $150,000	7.7	(4)	6.2	(5)
$150,001 to $250,000	9.6	(5)	8.6	(7)
More than $250,000	21.2	(11)	21.0	(17)

Three additional questionnaire items related to the source of funds used in program operation. One question sought information about funding received from various federal programs; Table 9 presents a summary of the data provided by the respondents. According to the data received, most of the surveyed programs do not receive federal funding. The only federal funding source used with some frequency by both groups was Title XX (Medicaid). In terms of a process for soliciting funds, most programs (73%) reported that fundraising had not been assigned to a specific individual. Among those who had assigned a specific person, 67 percent utilized a staff member, 5 percent a member of the board of directors, and 23 percent some other individual.

Table 9
Federal Funding Sources Utilized

	Exemplary %	Exemplary N	Non-Exemplary %	Non-Exemplary N
Health Funding Sources				
Title V	11	9	3	4
Title VI	1	1	2	2
Title X	1	1	2	3
Education Funding Sources				
Title I	5	4	3	4
Title IV B	4	3	4	5
Social Service Funding Sources				
Title XIX	7	6	2	2
Title XX	21	17	17	21

EVALUATIVE ACTIVITIES OF PROGRAMS

As a final line of inquiry, information was sought on the extent to which evaluation activities were conducted. The majority of the respondents (89% of the exemplary and 91% of the nonexemplary) indicated that staff were evaluated on a regular basis, most often annually or semi-annually; and 58 percent of the exemplary and 70 percent of the non-exemplary program respondents reported that the effectiveness of their program has been evaluated.

As part of the survey instrument, various criteria which could be utilized in evaluating a program were listed. Table 14 presents these results. Generally the exemplary programs reported a slightly higher use of health-related criteria while non-exemplary programs reported higher use of criteria related to education. This result is understandable given the higher percentage of health-based programs in the exemplary group and the higher percentage of education-based programs in the non-exemplary group.

The final items on the questionnaire were inquiries regarding the use of evaluations. Approximately 44 percent of the exemplary and 40 percent of the non-exemplary program respondents indicated that their evaluations were utilized in a formative fashion for program improvement and/or revision. Finally, 22 percent of the exemplary and 24 percent of the non-exemplary program respondents had published the results of their evaluations.

Table 10

Criteria Used for Program Evaluation

Criteria	Exemplary N=81	Non-Exemplary N=124
Healthy mothers	37%	40%
Good nutritional habits	33	33
Effective use of family planning	35	32
Incidence of repeat pregnancies	49	45
Incidence of low birth weight babies	41	34
Babies' health subsequent to birth	38	1?
Whether adolescents became self-supporting	31	37
Whether students stayed in school during pregnancy	52	46
Whether students stayed in school after delivery	53	57
Whether students stayed in school until graduation	43	59
Whether students entered post-secondary education	26	31
Whether students received job training	27	25

SUMMARY

There were a number of differences found between programs that were identified as exemplary and those not identified as exemplary by personnel in the state agencies. One major difference was the number of days involved in outreach services. In this area, exemplary programs spent more than twice as many days providing outreach service and had a higher number of days donated as well. This greater involvement in providing outreach services may account for these programs being better known by personnel in the state agencies and may be the basis for the nomination as exemplary. The non-exemplary programs served a higher number of pregnant adolescents/adolescent parents while the exemplary programs served a higher number of extended family members. The non-exemplary programs provided a higher average number of hours of in-service training for staff and volunteers. Exemplary programs were slightly more likely to receive federal funds. On the whole, however, these two groups were remarkably alike and both types of programs were involved in providing an array of health, education, social and other types of services to this population.

APPENDIX B

EXAMPLE OF STATE INTERAGENCY AGREEMENT

MEMORANDUM OF AGREEMENT BETWEEN THE DEPARTMENT OF HUMAN RESOURCES AND THE DEPARTMENT OF PUBLIC INSTRUCTION CONCERNING THE PROVISION OF SERVICES TO PREGNANT SCHOOL AGE GIRLS/SCHOOL AGE PARENTS FOR THE PURPOSE OF REDUCING INFANT DEATHS AND IMPROVING INFANT HEALTH

WHEREAS, school age pregnancy is an issue of national concern; and

WHEREAS, the age group 14 to 17 years is the only age group which reflects a statistically significant increase in the birth rate; and

WHEREAS, the pregnant school age girl is, by virtue of age alone, at risk for health outcomes; and

WHEREAS, the infant of the high risk mother is also at risk for poor developmental outcomes, e.g., prematurity, low birth weight and concomitant developmental disabilities and handicapping conditions; and

WHEREAS, the most reliable predictor of repeated school age pregnancy is failure to complete a high school education or achieve a vocational focus; and

WHEREAS, statistics have shown that many pregnant school age girls and school age mothers discontinue their education as a result of pregnancy and childbirth; and

WHEREAS, teachers and guidance counselors who often are the first person in whom a school age girl confides regarding her pregnancy need to be aware of the services available for her from the health and social agencies and to be assured of cooperation from these agencies; and

WHEREAS, the Department of Human Resources and the Department of Public Instruction place a priority upon ensuring all school age pregnant girls continued access to education, as well as assistance in securing needed medical services;

NOW, THEREFORE BE IT UNDERSTOOD that the Department of Public Instruction and the Department of Human Resources are promoting by way of this memorandum, local referral processes to ensure that all school age pregnant girls have access to continuing education and/or vocational training in addition to the necessary health and social services necessary to achieve the birth of healthy infants. Those local agencies having responsibility for implementing this agreement should remain cognizant of problems faced by pregnant school age girls in securing family support and consider ways in which family involvement might be facilitated in plans for medical care, social services, and continuing education. To achieve positive health and education goals, the two departments agree to the following:

I. That, when school authorities learn of the pregnancy of a school age girl, they will, with her consent, refer her for needed services to local departments of health and social services.

II. That, where appropriate, referrals should be made to local departments of social services for assistance in the following areas:

Problem Pregnancy Services, including arrangements for Maternity Home Care when appropriate
Health Support Services where available
Individual and Family Adjustment Services, including education and counseling about school related problems, parenting, child development, consumer affairs, etc.
Family Planning Services
Employment and Training Support Services
Foster Care Services
Day Care Services

III. That, local departments of social services in receiving referrals, in addition to providing services to the pregnant school age girl, will refer her to local health departments, as appropriate for services in the areas of:

Prenatal Care
Family Planning
Pregnancy Counseling
Special Supplemental Food Program for Women, Infants and Children

IV. That, when a pregnant school age girl is referred to a local health department, the public health nurse will determine if she is in the care of a private physician or if she has access to medical services for the duration of her pregnancy; that the public health nurse will urge her to secure adequate prenatal care; that, in the event of need, the public health nurse will refer the school age girl to the prenatal and WIC programs within the local health department;

V. That the local school system and the local human service agencies will work closely together in developing continuing educational alternatives and day care options to ensure that the pregnant school age girl or the school age mother does not drop out of school;

VI. That the local service agencies will ensure that the school age mother and her infant will continue to receive health and social services as needed, and that the local school system will assure that she receives counseling and educational services that will support her in her effort to complete her education.

APPROVED:

DATE: July 9, 1980

Sarah T. Morrow, M.D., M.P.H.
Secretary
N. C. Department of Human Resources

A. Craig Phillips
State Superintendent of
Public Instruction

EXAMPLE OF LOCAL INTERAGENCY AGREEMENT

STATE OF TEXAS

COUNTY OF TRAVIS

CONTRACT NUMBER _____

CHILD CARE SERVICES CONTRACT

1980 - 1981

I. CONTRACTING PRIORITIES:

This contract is entered into by and between the education institutions shown below as contracting parties:

The Receiving Party: THE AUSTIN INDEPENDENT SCHOOL DISTRICT

The Performing Party: CHILD, INCORPORATED

II. STATEMENT OF SERVICES TO BE PERFORMED

A. The performing party will:

1. Provide basic, quality child care spaces for at least 55 children of AISD students as approved by the AISD Education for Parenthood Project Coordinator.

2. Provide said child care for 8 hours per day for AISD school days from August 26, 1980 to May 29, 1981.

3. Provide said child care in compliance with the Federal Interagency Child Care Requirements, and the Texas State Minimum Day Care Standards, and to the specification of the AISD Education for Parenthood Coordinator.

4. Child, Incorporated will provide the AISD Education for Parenthood Coordinator with an accounting of all charges to the AISD-Child, Inc. infant centers.

B. CONTRACT AMOUNT

In return for said child care services, the Austin Independent School District will reimburse Child, Incorporated as follows:

[Specifics On Amounts Have Been Deleted]

C. PAYMENT FOR SERVICES

1. Services for this contract shall be billed monthly by child care space provided, not to exceed the following:

	No. Days	Monthly	Cumulative
August - September	25	[AMOUNTS DELETED]	
October	23		
November	16		
December	15		
January	18		
February	20		
March	22		
April	17		
May	21		

2. The Receiving Party agrees to pay such charges within thirty (30) days of receipt in the AISD Finance Office.

III. RESPONSIBILITIES OF RECEIVING PARTY

A. SUPERVISION

The AISD Education for Parenthood Project coodinator will supervise the AISD-Child, Inc. infant centers and will be responsible for approving personnel, purchasing, the education program, and other aspects of providing quality child care for the children of AISD students.

B. FISCAL APPROVAL

The AISD Education for Parenthood Program coordinator will approve all purchases and charges to the AISD Infant Center budgets.

IV. CONTRACTING VOIDING

By mutual consent of both parties, this contract may be declared null and void with thirty (30) days written notice, or if the regulation and/or funding agencies of either party discontinue funding for this program.

Other NASBE publications on Adolescent Parenthood:

Manual of State Policies Related to Adolescent Parenthood
($75.00)

Overview of State Policies Related to Adolescent Parenthood
($15.00)